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TEXAS MEDICAL ASSOCIATION • JANUARY 1992

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under siege:

THE *Embattled Trauma Care System*

llegal remuneration statute stops "bounties" for patient referrals / 26, 68 • Rural Health Clinic Program: claims of abuse / 60 • Limited liability partnerships offer new option / 69

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Cover photograph by David C. MacKenzie.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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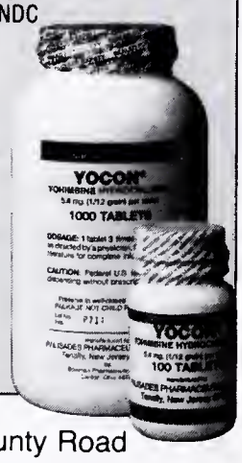

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Zantac® Tablets

ranitidine HCl/Glaxo 150 mg tablets bid

WHEN ACID REFLUX ERUPTS

Please see Condensed Brief Summary of Prescribing Information on adjacent page.

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Zantac® 150 Tablets
(ranitidine hydrochloride)
Zantac® 300 Tablets
(ranitidine hydrochloride)
Zantac® Syrup
(ranitidine hydrochloride)

CONDENSED BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy and is maintained throughout a 6-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug

PRECAUTIONS: General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to Zantac® administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25°C (39° and 77°F). Dispense in tight, light-resistant containers as defined in the USP/NF.

September 1991

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Research Triangle Park, NC 27709

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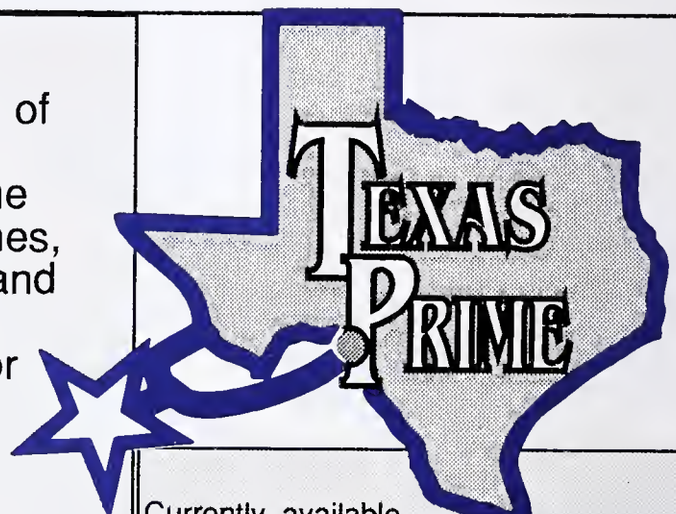

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Letters

Let's talk to our patients

LET'S ADMIT IT. AS PHYSICIANS, we feel we are steadily losing control of our practice environment. We are challenged by government, third party payors, and the media — all of which gradually are eroding our financial base and our public image.

In this turbulent environment, our last and best allies are our own patients. Although many Americans are exposed to an unfavorable image of physicians from the media, virtually the same number *do* see their physicians. By their very presence, our patients are giving us a vote of confidence. Let's take advantage of this. Why not add a minute or two to each patient's visit to discuss the issues we feel are eroding the quality of the health care we can provide them? Let's talk to our Medicare patients about what impact further Medicare cuts will have on their care.

This type of conversation can educate patients as to the realities of health care in this country. Educating our patients will help make them less likely to readily believe the negative stories that abound and will give them a greater appreciation of our role as advocates for quality health care.

In our oncology group practice, the vast majority of our patients receive chemotherapy in the office. Many patients tell me they vastly prefer to receive this care in the office, rather than be subjected to the inefficient and impersonal care that often occurs in hospital outpatient settings. When I tell them that with further Medicare cuts in reimbursement for intravenous pharmaceuticals, we will be "out of business" and they will have to go back to the hospital for their chemotherapy, they are shocked and upset. It is an easy next step to ask them to contact their representatives in the American Association of Retired Persons, as well as their elected representatives, to state their case.

Our best allies in every political arena are our own patients. Because as you and I know, it's not just our image that's at stake, it's our patients' quality of care. So let's not lose our last and most powerful supporters. A few minutes spent discussing with our patients how economic and political issues will impact the quality of care we are able to offer, I know, will recruit an army of ardent backers.

Gary E. Gross, MD
Member, TMA Council on Communication
1107 Doctors Dr,
Tyler, TX 75701.

Protesting mandatory HIV testing of physicians

I HAVE BEEN A MEMBER OF Texas Medical Association since 1975 and have supported most of the association's issues, but I must protest the TMA's support of the HIV notification law passed this year. Did you poll your members before you decided to okay this "Mickey Mouse" law?

I would have thought that the TMA would only support this law if it also required patients to notify medical personnel when they are HIV-positive. According to the Centers for Disease Control and all I have read in the last 10 years, medical personnel are more at risk than patients.

How could the TMA allow hysteria and some funky lawmakers to bully it into allowing this bill to pass without so much as a whimper? I must protest in the strongest language possible the TMA's position on the law. I would hope the TMA would insist the law also make provisions, with the same penalty, for patients to notify health-care workers if they are HIV-positive.

If the TMA does not protest publicly, I can tell you the association will lose a great deal of respect and credibility among its members, in addition to their support. The Texas physicians in the trenches expect the TMA to look out for them in the legislature. For once and all time, the TMA needs to stand up and be heard, for failure to do so will be the end of private practice as we know it now.

Physicians should not be unilaterally subjected to more rules, laws, regulations, and tests. We are constantly putting ourselves at risk treating patients with highly contagious and communicable diseases, and physicians are also entitled to protection from inconsiderate individuals. We should have the right to test prospective patients for AIDS, and patients who know they are HIV-positive should have a legal responsibility to disclose this information to us.

Michael W. McShan, MD, PhD
738 Hwy 259 N,
Kilgore, TX 75662.

Legal 'doctorcide'?

AS A PHYSICIAN, I HAVE been appalled by many aspects of the handling of our AIDS epidemic, but the latest turn of events is truly a blow — not only to medical personnel, but to patients as well. Recent legislation now requires HIV-positive physicians and health personnel to inform their patients

before performing a procedure.

Unfortunately, the same consideration was not given to health personnel — patients do not have to tell doctors if they are HIV positive. Nor can they legally be tested against their will.

With a lethal disease that has an asymptomatic infectious incubation period of weeks to months, even a child can figure out that an infected patient could infect a doctor who could unknowingly risk spreading it to patients for a long time before testing positive. The low number of cases transmitted between patients and health-care workers, in either direction, speaks to the need for less panic.

For the life of me, I do not understand why it is not punishable as homicide to knowingly risk spreading a lethal disease, when it could have been prevented. Nor do I understand why it is not okay for doctors, especially in high-risk fields such as surgery or gynecology, to defend their lives by testing their patients, rather than trusting the lives of themselves and their future patients to the integrity of someone who is infected.

I find it incomprehensible that our state medical society could support this legislation! AIDS is indeed a dreadful problem, but there are logical rational steps to take that should apply to everyone:

1. Each of us must take responsibility for not spreading this, or any other disease, to our fellow human beings. If in doubt, show the precautions you would want shown to your own child! Panic, however, is not a responsible behavior.
2. Continue educating people about the mode of disease transmission, so they better know how to avoid catching or spreading it.
3. We must avoid deluding ourselves either about our safety or our relative 'moral superiority' by saying that this is "only a disease of gays and druggies."
4. Should people with the disease be identified? Yes, but across the population, not just doctors or other select groups.

Let's not legalize killing our doctors in a rush to run away from our fears about this disease!

Judy Cook, MD
6750 Hillcrest Plaza Dr, Suite 306,
Dallas, TX 75230.

TMA's response

TMA HAS BEEN ACTIVE IN working toward sensible and sensitive legislation concerning AIDS since 1987. For guidance in formulating its policy, the association has relied on the recommendations of its own scientific committees and other physicians who are active in fighting this disease.

Two points about current Texas law need to be clarified: (1) A physician does have the right to require that a patient take an HIV test prior to performing a procedure that, in the judgment of the Texas Department of Health, could pose a risk of exposure to the physician, if there is time to get the test results before the procedure is performed; and (2) The recently enacted legislation does not require a physician to notify patients of the physician's HIV-status except in the circumstance of an exposure-prone invasive procedure. The act does not mandate testing of health-care workers for HIV and hepatitis B, but states that those who perform exposure-prone invasive procedures should know their HIV status. The bill specifies that all health-care workers should adhere to universal precautions for infection control, that workers positive for HIV or hepatitis B should perform exposure-prone procedures only under circumstances spelled out by an expert review panel, and that HIV- and hepatitis B-infected health-care workers must notify prospective patients of their seropositive status and obtain patients' consent *before performing exposure-prone invasive procedures.*

In effect, the Texas statute runs parallel to accepted standards of care. For a physician to willingly and knowingly risk infecting his or her patients would violate the standard of care.

Fred F. Castrow II, MD
Chairman, TMA Council on Legislation
7777 Southwest Freeway, #1014,
Houston, TX 77074-1856.

Don't lump all animal rights activists together

I WAS GETTING SOME MATERIAL together on animal experimentation and came across your article from 1990 ("A vital choice: animals in research," *Texas Medicine*, July 1990, pp 20–31) and somehow it became important to me to write and let you know that we (the animal rights people) are not what some of your contributors would have you believe.

Most of us are just very ordinary people and the thought of death threats and bombs is abhorrent to us.

We just go along and try to make it better for animals that have to suffer. We have no desire to hurt anyone or to disrupt any *legitimate* re-

search. I have stressed the word legitimate because many of us in the profession have serious questions about whether a lot of research could be so classified. Some of it, but of course not all of it, is motivated by desire for grant money.

I just wanted you to know that we are not monsters or terrorists. Most of us are interested in preventing abuse of helpless people as well as helpless animals, but we work against a very powerful lobby that tries to create the impression that we want to prevent research that would benefit little children. I can assure you that this is not the case. We do not, however, have the resources to counteract the TV attacks on our efforts.

Norma E. Harris, MD
2922 Bellaire Blvd,
Houston, TX 77025.

***Express your point of view in* Texas Medicine.**

To submit a letter, send it to Texas Medicine, *TMA, 401 W 15th St, Austin 78701. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.*

winter
LEADERSHIP
CONFERENCE
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AUSTIN

Building Strength Through Leadership

- Hear why strong physician leadership is a key ingredient for survival in these changing times from the Speaker of the AMA's House of Delegates, **Daniel H. Johnson Jr., MD.**
- Take a look at legal issues facing medicine from **B.J. Anderson, JD,** special counsel in the AMA's Office of the General Counsel.
- Find out the inside story about health-care reform measures being considered on Capitol Hill from **U.S. Sen. Lloyd Bentsen,** D-Texas.
- Explore the pros and cons of managed care as a solution to rising health-care costs from a panel of authorities.
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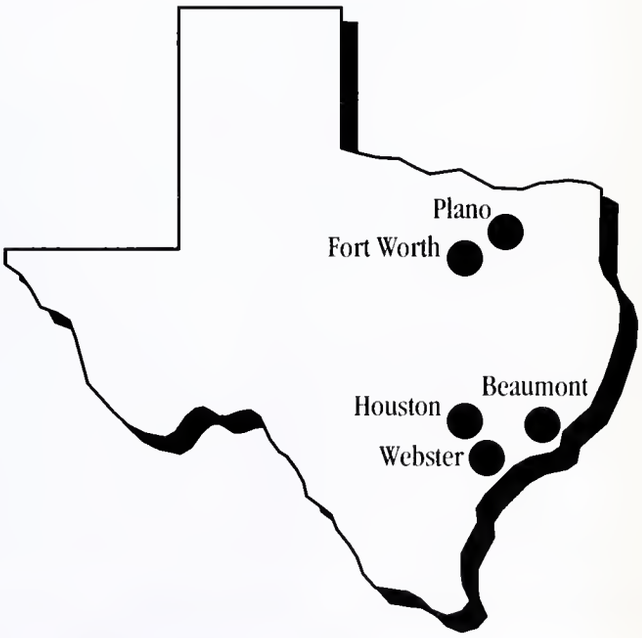

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Upfront

Dial "800" number for toll-free access to TMA

GRAB A PENCIL AND YOUR Rolodex (or your electronic phone directory if you're the hi-tech type). Next to "Texas Medical Association" write **(800) 880-1300.**

That's the new toll-free number for TMA members to use in calling all TMA departments. If you get a busy signal, you may wish to dial TMA's main number, (512) 370-1300, to reach the TMA switchboard. Or the direct-to-desk phone lines of individual staff members can be used.

Citing the number's capacity for improving communication between members and the association, TMA President Sam A. Nixon, MD, Houston, said, "This is a membership service our members deserve. It means members can call the association very rapidly, get the information they need, whether it's from the executive vice president, the library, the general counsel, or whomever, and then can get back to work very quickly."

Originally proposed by the Clay-Montague-Wise County Medical Society, the resolution to install a toll-free telephone line for members was referred by the House of Delegates to the association's Board of Trustees in November 1990. After studying the projected cost of the telephone line, the board approved the service to begin January 1, 1992.

Based on data from the American Medical Association, which has a toll-free number for members, TMA anticipates from 120 to 230 calls per day from members.

Among the things you can do by calling (800) 880-1300 are check on your membership status, ask about membership benefits, use the TMA library, find out about upcoming TMA meetings, get information on TMA workshops and other continuing medical education opportunities, ask questions about Medicare and Medicaid reimbursement (and other medical economics topics), find out about the association's legislative activities, learn about your legal rights, inquire about travel possibilities, and change your address.

Calls to the Texas Medical Association Insurance Trust should continue to be made to their toll-free line, (800) 880-8181.

Texas Medicine will publish the TMA toll-free number each month in its masthead on page 4 and will include the number in addition to any staff member's direct phone line mentioned in an article.

House of Delegates confronts full catalog of medical issues

GRAPPLING WITH ISSUES ranging from health-care reform to guidelines for HIV-infected physicians, the Texas Medical Association House of Delegates met in Austin November 15–16.

Action taken by delegates is reported below and in the public health and medical economics sections of this issue of *Texas Medicine.* Next month's science and education section also will contain information on House action.

Organizational and financial decisions of the House included:

- approval of a recommendation to support legislation to provide indemnification or other protection from medical liability for physicians who volunteer free medical

TMA LEADERSHIP CONFERENCE AIMS FOR STRENGTH

RECOGNIZING THAT STRONG physician leadership is key to the medical profession's health, TMA designed its 1992 Winter Leadership Conference to help boost your knowledge of critical issues.

Scheduled February 29, 1992, at the Stouffer Austin Hotel in Austin, the main conference is free to TMA members and association guests.

Speakers for the conference include US Sen Lloyd Bentsen (D-Tex); Daniel H. Johnson Jr, MD, speaker of the American Medical Association's House of Delegates; B.J. Anderson, JD, special counsel in the AMA's office of the general counsel; and John Deane, executive director of UT-MED in Galveston, who will explore the pros and cons of managed care as a solution to rising health-care costs.

Special sessions will focus on ways to improve communication with your patients and in your community and ways to better manage your practice.

The conference program will be held from 9:30 am to 12:30 pm, followed by a luncheon sponsored by the Texas Medical Association Insurance Trust. Afternoon sessions are planned from 2 to 5 pm.

Most of TMA's 40 boards, councils, and committees will meet during the conference weekend.

Preregistration is suggested but not required for those who plan to attend the conference. For further information, contact Jon R. Hornaday, TMA Special Services, (800) 880-1300 or (512) 370-1346.

service in a non-emergency setting;

- approval and referral to the Council on Legislation of a recommendation to support legislation in the 73rd Texas Legislature to provide for consent for medical and surgical treatment by appropriate surrogate decision-makers on behalf of incompetent or comatose patients;
- referral to the Committee on Professional Liability of a recommendation to seek statutorily to require that all expert witnesses at medical malpractice proceedings be licensed in Texas and be engaged in the private practice of medicine as defined by state law, and recommendation to seek legislation to provide that the act of being a medical expert witness be considered the practice of medicine;
- approval of a recommendation to commend the AMA for responding to members' concerns by announcing a new journal for family practitioners, and to urge the AMA to provide a specialty journal to members at no charge;
- referral to the Council on Annual Session and Scientific Programming of a recommendation that the association schedule its annual session in Austin each odd-numbered year when the Texas legislature is in regular session.

As a result of House action, the Texas Delegation to the AMA was scheduled to carry 10 resolutions to the AMA House of Delegates Interim Meeting in December. Those resolutions addressed a range of issues, including labeling of generic drugs, access to physician services in rural health clinics, patient reporting of HIV status, physician authority to test possible HIV-infected patients, and allowance of some exceptions for private office laboratories to the anti self-referral law.

The 436 members of the TMA House of Delegates considered more than 80 items for action, in addition to the numerous items received for information only.

James C. Mann, Jr, MD, to receive Distinguished Service Award

THE HIGHEST HONOR BESTOWED by the Texas Medical Association, the Distinguished Service Award, will be presented to James C. Mann, Jr, MD, Beaumont, at the TMA Annual Session in May.

At its meeting in November, the TMA House of Delegates confirmed the nomination of Dr Mann by the TMA Board of Councilors.

Dr Mann, a former chairman of the TMA Board of Councilors, is a general practitioner.

He received his bachelor's degree in economics from Southern Methodist University and graduated from The University of Texas Southwestern Medical School. He served an internship at the US Public Health Service Hospital in Seattle, Wash.

Dr Mann has served organized medicine widely, including service on many TMA committees and as a TMA delegate. He also was president of the Beaumont Academy of Medicine, president of the Tenth Medical District, and member of the board of trustees of Texas Medical Foundation. He served as chief of staff of Beaumont Municipal Hospital and as a member of many of its committees.

Dr Mann's teaching appointments include instructor of The University of Texas Medical Branch family practice residency program at St Mary's Hospital in Port Arthur and volunteer faculty at the Law Enforcement Academy at Lamar University.

NIXON EXPRESSES FRUSTRATION: "OH, THOSE 'EXTERNALS'!"

POINTING OUT THAT PHYSICIANS need to be advocates for what's *right* for their patients, TMA President Sam A. Nixon, MD, Houston, called on the House of Delegates to focus not only on the needs and rights of physicians, but also on those of patients.

But noting physicians' frustration with government intrusion into the patient-physician relationship, Dr Nixon made reference to the first aphorism of Hippocrates and quipped, "Oh those 'externals!' How do we get them to cooperate?"

The first aphorism of Hippocrates states, "Life is short, and the Art long; the occasion fleeting; experience fallacious; and judgment difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate."

Dr Nixon said, "Patients need us to advocate for access to care. And for health insurance. And to work in concert with them on difficult issues such as AIDS, health-care costs, and ethical decisions. The complex political, regulatory, and legal climate challenges our efforts to keep the patient-physician relationship healthy."

Dr Nixon also reminded delegates of the challenges facing the medical profession in Texas during the 1993 session of the Texas legislature, including the sunset review of the Medical Practice Act. "We've already launched an extensive and aggressive plan to . . . maintain one of the strongest medical practice acts in the nation," said Dr Nixon.

In calling for active participation in TMA, Dr Nixon reminded TMA members that "the door is wide open for those of you and your colleagues who are interested and willing to serve on boards, councils, and committees — and to run for office. . . . So what if you don't get elected on the first or second time out? It's no disgrace to lose; the disgrace is in not trying at all."

Four physicians elected to honorary membership

TMA'S HOUSE OF DELEGATES bestowed honorary membership to four Texas physicians during interim session in November.

The physicians are Guy K. Driggs, MD, Dallas; Billy Rual Jones, MD, Amarillo; James M. Keegan, MD, Houston; and Charles M. Sloan, MD; Dallas.

Upon nomination by component county medical societies, the House of Delegates may elect to honorary membership those physician members "who have rendered outstanding service to organized medicine or made noteworthy contributions to scientific medicine and who have reached a point of comparative inactivity in the practice of medicine as determined by the county medical society."

Firearm-mortality article attracts national notice

STATE AND NATIONAL NEWS coverage of an article on firearm-related mortality published in the November 1991 issue of *Texas Medicine* greatly surpassed the hopes of the article's authors.

"Firearm-related mortality in Texas (1985–1990)" attracted the attention of Cable News Network (CNN), *The New York Times*, *Chicago Daily Herald*, the Associated Press, Reuters news service, and other national media.

CNN featured a 2½-minute segment that also ran repeatedly on CNN Headline News.

In Texas, the *Austin American-Statesman*, *Dallas Morning News*, *Houston Chronicle*, *El Paso Herald-Post*, *Fort Worth Star-Telegram*, *San Antonio Light*, and numerous other newspapers ran articles based on information in the article. KHOU-TV in Houston and other television and radio stations also carried the story.

The article reported that firearms surpassed motor vehicles as the leading cause of injury mortality in 1990 in Texas. Motor vehicles had been the leading injury killer in the state since vital records were computerized in 1964. There were 3,443 deaths related to firearms and 3,309 motor vehicle-related deaths in 1990 in Texas.

One of the article's authors, Patti J. Patterson, MD, MPH, associate-ship for personal health services, Texas Department of Health, says she doesn't think even supporters of the rights to gun ownership really understood the magnitude of the firearm-mortality problem.

"In 1990, there were more gun deaths than car deaths in 66 Texas counties," said Dr Patterson. "That's 26% of the counties in Texas." She adds that the dominance of gun deaths over car deaths has been true in Houston for 10 years.

Dr Patterson's coauthors were David F. Zane, MS, Mary Jo Preece, and Erik K. Svenkerud, MD, MPH. The article appeared on pp 63–65 of the November issue of *Texas Medicine*.

Physicians speak out for positive side of medicine

NOW'S YOUR CHANCE TO speak out about how you and your colleagues are "Physicians Caring for Texans" through Texas Medical Association's physician recognition program. Initiated by the Council on Communication, the program works to counteract the

negative image of medicine and, at the same time, promote association positions and priorities. By telling your story, you can help the public understand the positive efforts of physicians throughout the state.

With your input, TMA's public relations department staff draft articles for print publication. Your expertise and insight are vital to make the issues come alive. Once the article is drafted, public relations staff work to place it in an appropriate newspaper or magazine.

In 1991, TMA successfully placed 10 articles on topics ranging from tobacco to mandatory AIDS testing to access to health insurance. Editorials ran in newspapers from Dallas to Galveston.

The goal for the second year is to expand the focus and increase the number of placements. Heading the list of topics for 1992 are access to health care and health insurance, science and science education, ethics/AIDS, and reimbursement.

If you're interested in authoring articles in these and other areas of public interest, call Tammy Wishard in TMA's public relations department, (800) 880-1300 or (512) 370-1391.

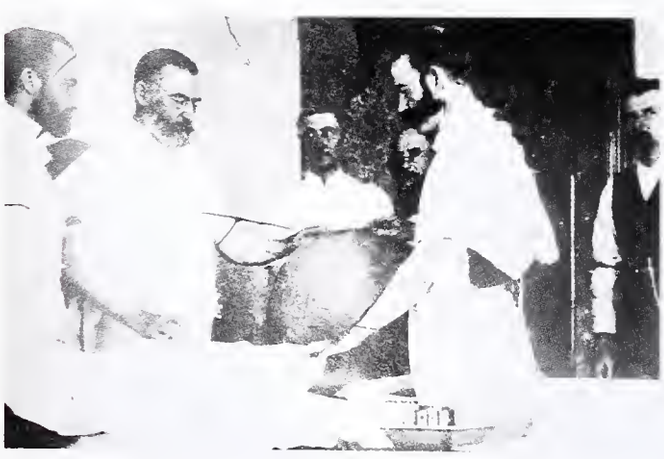
Ovarian cyst falls short of Texas record

THEY SAY EVERYTHING IS BIGGER IN TEXAS. That appears to hold true at least for ovarian cysts.

When doctors at Stanford University Hospital removed a 303-pound ovarian cyst from a 34-year-old woman on October 25, they thought they had a record. However, when a *Physician's Weekly* reporter made a quick check with officials from the *Guinness Book of World Records*, he found that the Stanford docs had come up 25 pounds light of the record set right here in Texas.

That's right. Noted Corpus Christi physician Arthur E. Spohn, MD, set the record in 1905 when he removed a 328-pound tumor from a 43-year-old mother of seven.

"When called to see her, imagine my surprise on entering her room to find on the bed an immense mass as large as a barrel," Dr Spohn wrote in an article that appeared in the February 1906 issue of the *Texas State Journal of Medicine* (the previous name of *Texas Medicine*). "I could not see the woman, but in looking over the mass could just see her head attached to it like an appendix."



Dr Arthur E. Spohn (second from left) removed a 328-pound tumor from this patient in 1905. Photograph courtesy of Spohn Hospital, Corpus Christi.

Dr Spohn drained 30 gallons of gelatinous fluid from the cyst over a 1-week period before operating. Despite excessive bleeding and other complications, the surgery was successful and the patient made a full recovery. ★

SAN ANTONIO

GENERAL SESSIONS TO SPARK 125TH ANNUAL SESSION

DO YOU HAVE QUESTIONS about the latest clinical techniques and procedures in your specialty? The new Medicare payment schedules? Ways to improve your practice? Your own professional image? Find answers to these and countless other pressing questions in San Antonio during Texas Medical Association's 125th Annual Session, May 14–17, 1992.

More than 40 scientific programs in every specialty will be presented over a 4-day period, with emphasis on topics of interest to primary care physicians. On Saturday, May 16, general sessions in a "town hall" format will be presented. Topics to be explored in the general sessions include the public image of the physician, an overview of the new Medicare payment system, ways to improve practice productivity, and methods of understanding and improving third party reimbursement.

No general registration fee will be charged to TMA members.

Special displays and exhibits are planned to emphasize pertinent points in scientific presentations. Technical exhibits representing pharmaceutical companies, medical services, office and computer equipment, and a host of other products and services of interest to physicians also will be on view.

San Antonio's fiesta atmosphere and many Riverwalk attractions will provide an exciting background for the meeting, which will be headquartered in the downtown San Antonio Convention Center. Social and sports activities will round out the annual event.

For more information, see the four-page Annual Session insert beginning on page 55 of this issue.

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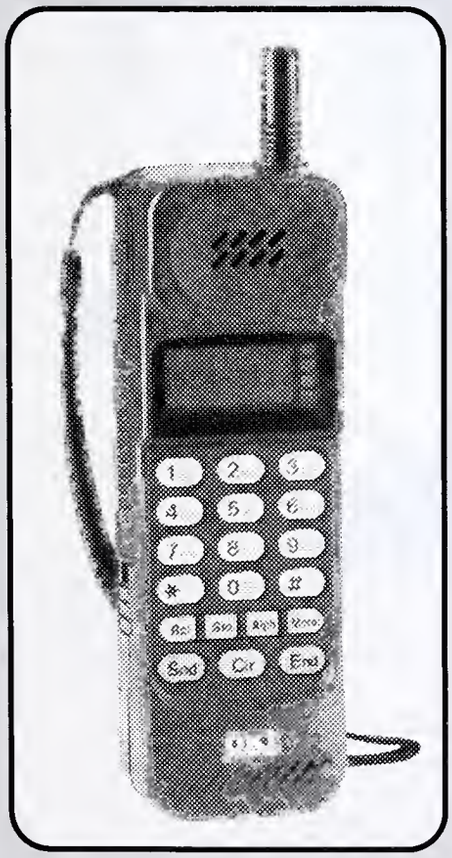

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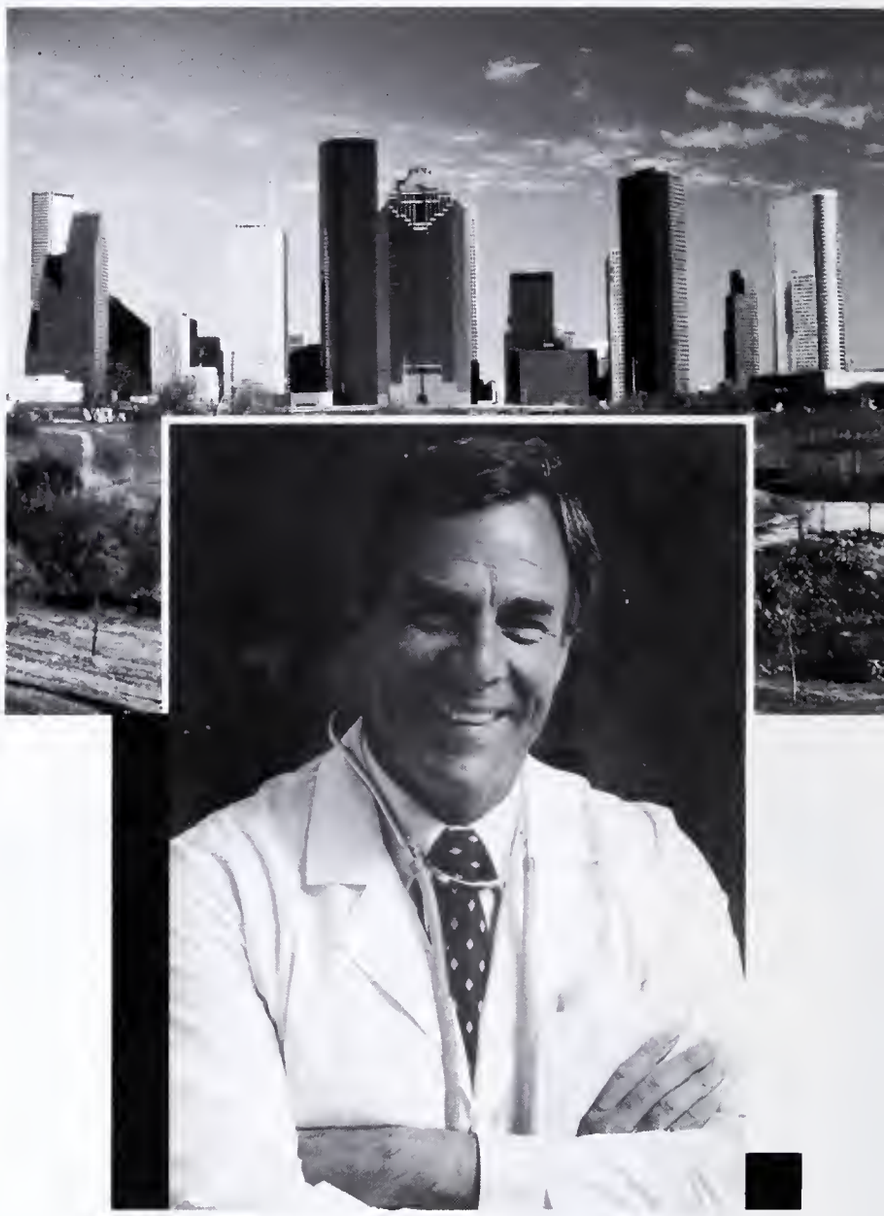

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People

NEWSMAKERS

John R. Coppedge, MD, Longview general surgeon, has been appointed to the board of directors of the State Bar of Texas. He serves as one of six representatives of the public on the 46-member board.

A newly endowed chair at The University of Texas Medical School of Houston has been established in honor of **Cecil M. Crigler, MD.** Dr Crigler is currently professor emeritus in urology at the UT medical school.

The American Academy of Otolaryngology — Head and Neck Surgery has elected **G. Richard Holt, MD,** to the office of president, and has presented **David Barrs, MD,** with an honor award. Both Dr Holt and Dr Barrs practice in San Antonio.

Richard L. Plumb, MD, clinical professor of pediatrics at Baylor College of Medicine, has been elected president of the Texas Pediatric Society.

Margaret R. Spitz, MD, associate professor of medicine in the department of cancer prevention and control at The University of Texas M.D. Anderson Cancer Center, was presented the 1991 Julie and Ben Rogers Award for Excellence by the M.D. Anderson Cancer Center. The annual award is presented to an M.D. Anderson staff person in recognition of excellence in the areas of administration, research, patient care, education, and prevention.

Please let *Texas Medicine* know about your honors and achievements.

Criteria for inclusion in the Newsmakers section are: TMA member; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, Texas Medicine, *401 W 15th St, Austin, TX 78701.*

OBITUARIES

Thomas Alfred Anderson, Jr, MD, 68; Seabrook; University of Virginia Medical School, 1946; died October 27, 1991.

Forest C. Barber, MD, 73; Fort Worth; University of Oklahoma School of Medicine, 1950; died October 31, 1991.

George W. Beeler, MD, 84; Grapeland; The University of Texas Medical Branch at Galveston, 1932; died October 15, 1991.

Allan Penny Bloxsom, MD, 89; Houston; Johns Hopkins University School of Medicine, 1927; died October 12, 1991.

Mathew DeVore Burnett, Jr, MD, 73; Houston; The University of Texas Medical Branch at Galveston, 1941; died October 24, 1991.

Perry Leroy Bursey, MD, 74; Fort Worth; The University of Texas Medical Branch at Galveston, 1941; died October 31, 1991.

H. Byron Daily, MD, 71; Houston; The University of Texas Medical Branch at Galveston, 1944; died September 17, 1991.

Eldon B. Fine, MD, 79; Waco; The University of Texas Medical Branch at Galveston, 1937; died October 22, 1991.

Sanford Williams French III, MD, 79; San Antonio; George Washington University School of Medicine, 1939; died October 1, 1991.

Elmer John Hawkins, MD, 69; Hamlin; Baylor University College of Medicine, 1945; died September 25, 1991.

James Robert Jacob, MD, 44; Spring; University of Zurich Medical School, 1975; died March 1, 1991.

Frank Herbert Jordan, Jr, MD, 85; Dallas; Meharry Medical College, 1934; died September 24, 1991.

Samuel Joseph Feducia, MD, 81; Houston; Tulane University School of Medicine, 1934; died October 16, 1991.

Robert E. Lau, MD, 74; San Antonio; Thomas Jefferson University, 1942; died August 16, 1991.

Kenneth L. Nelson, MD, 84; Bryan; University of Minnesota Medical School, 1936; died September 26, 1991.

John Wesley Padgett, Jr, MD, 71; Killeen; The University of Texas Medical Branch at Galveston, 1951; died October 2, 1991.

Terry Leon Pulse, MD, 40; Dallas; The University of Texas Medical Branch at Galveston, 1978; died September 29, 1991.

Rex Lee Repass, MD, 49; Austin; The University of Texas Southwestern Medical School, 1967; died October 27, 1991.

Cecil Alfred Robinson, MD, 89; Kermit; Baylor University College of Medicine, 1933; reported deceased.

Leonard F. Sayers, MD, 49; San Antonio; The University of Texas Medical Branch at Galveston, 1972; died September 29, 1991.

Pete Joe Starr, MD, 83; Arlington; Baylor University College of Medicine, 1942; died October 31, 1991.

Clayton J. Traylor, MD, 86; Waco; University of Kansas School of Medicine, 1932; died October 7, 1991.

Thomas Ousley Walton, Jr, MD, 75; College Station; Baylor University College of Medicine, 1940; died October 27, 1991.

John James Young, MD, 82; El Paso; Tulane University School of Medicine, 1936; died August 4, 1991.

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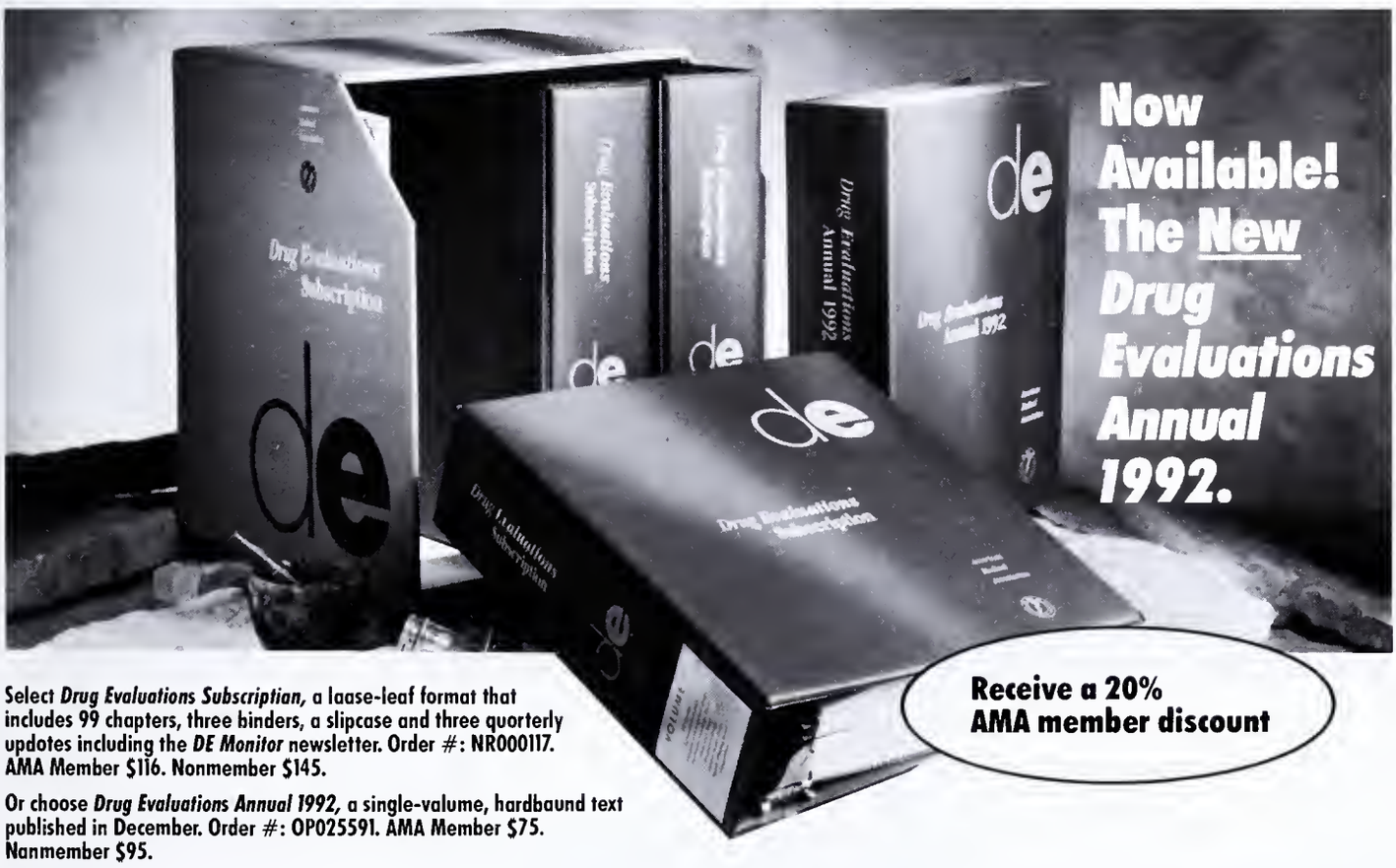

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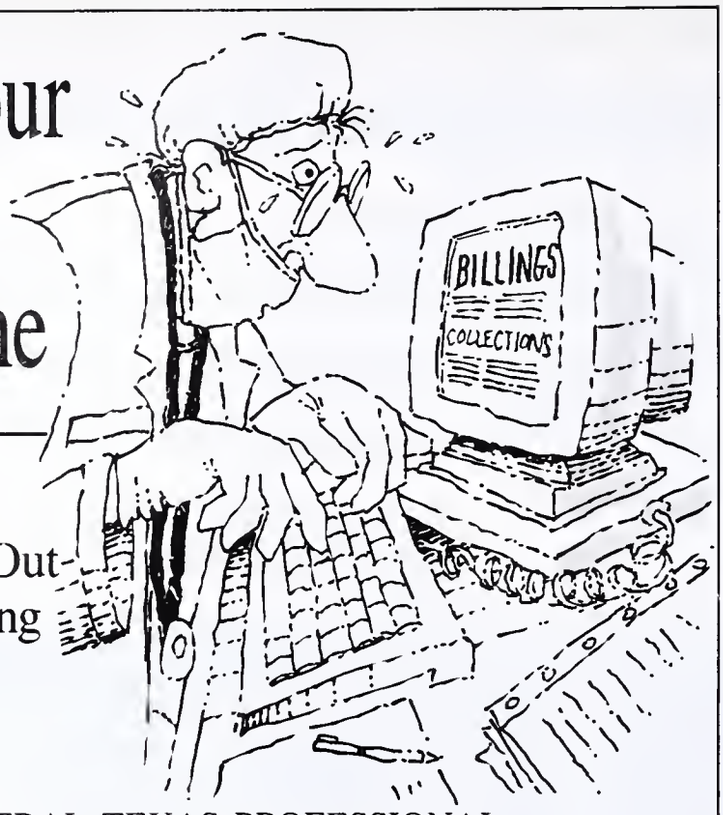

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Legislative Affairs

Senate panel likely to recommend additional limits on psychiatric hospitals

TEXAS MEDICAL ASSOCIATION played a key role in the passage of legislation last year putting an end to practices by some corporate psychiatric hospitals of paying "bounties" for patient referrals. Now one of the sponsors of that legislation is again calling on organized medicine to help end other psychiatric hospital "horror stories."

"Anyone would be horrified by some of the sworn testimony we've heard," said Sen Judith Zaffirini (D-Laredo), who is a member of a special Senate committee conducting public hearings into unethical practices at psychiatric hospitals across the state. "For example, we heard from a psychologist who worked at one of the hospitals who talked about the cheerleading meetings that were held regularly and how every employee of the institution was expected to recruit patients."

The close examination of psychiatric hospitals was prompted by the case of a 14-year-old Live Oak boy who was admitted to Colonial Hills Hospital in San Antonio against his parents' wishes and without a court order or mental detention warrant. State Sen Frank Tejeda, a Democrat and attorney from San Antonio, was hired to represent the family and obtained a court order for the boy's release, but only after the boy was hospitalized for 5 days.

Senator Tejeda brought the matter to the attention of a Senate subcommittee chaired by Senator Zaffirini during the special legislative session this summer. The two senators, with the help of TMA, Texas Hospital Association, Texas Society of Psychiatric Physicians, and others, pushed through legislation to block such practices. The new law prohibits hospitals, other health-care institutions, and health-care professionals from making or accepting payments for patient referrals.

"TMA took a leadership role in developing it (the legislation), for which we're grateful," Senator Zaffirini said.

"The significance of this legislation is far reaching and goes far, far beyond this isolated issue," said Kim Ross, TMA director of public affairs. "The legislation was a major step in blocking the drift toward the corporate control of medicine."

However, the issue was not put to rest by the legislation. Evidence of other types of abuses prompted a deeper probe into the problem by a special interim committee. The panel is chaired by Sen Mike Moncrief (D-Fort Worth) and includes Senator Zaffirini and Sen Chris Harris (R-Arlington).

During hearings in San Antonio, Houston, and Austin in November and December, the panel heard testimony about a wide range of unethical practices, including testimony that one hospital had a policy of keeping patients hospitalized for at least 1 month regardless of medical need.

"We've seen a whole pattern of admitting patients and then treating patients . . . and then determining the length of stay based on the availability of insurance instead of on the care needed by the patient," Senator Zaffirini said. "So the emphasis, in some cases, has been on profit."

Mr Ross said those types of "predatory behaviors" are the result of the creation of insurance coverage with no criteria for oversight and utilization review in the area of chemical dependency and substance abuse.

> THE NEW LAW PROHIBITS HOSPITALS, OTHER HEALTH-CARE INSTITUTIONS, AND HEALTH-CARE PROFESSIONALS FROM MAKING OR ACCEPTING PAYMENTS FOR PATIENT REFERRALS.

"That has resulted in an overnight boom in the growth of psychiatric hospitals coming into Texas owned by major corporations with tremendous marketing clout but absolutely no understanding of what would be appropriate in the mental health-care field ," said Mr Ross.

Senator Zaffirini said she is increasingly concerned that "these horror stories" will keep people who need help from seeking it. "Where do they go? How do they protect themselves?"

The senator said the first step in solving the problem may be legislation to hit the pocketbooks of those abusing the system for profit.

"For one thing, we clearly need criminal penalties and a scale of daily fines for violations of these laws because we're talking about peoples' lives, peoples' minds," she said. "We clearly have to have a means of getting the attention of the perpetrators. If the bottom line is profit, then we have to speak the same language and cut into that profit."

The senator also would like to see agencies that license psychiatric

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Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs sections of* Texas Medicine.

hospitals and substance abuse programs given the authority to make unscheduled examinations of those facilities and programs. Right now, those agencies can investigate facilities only when a complaint is filed.

"We need to work with doctors, with psychiatrists, with providers, with victims and their families, with consumers to insure that we develop the kinds of regulations that can make a difference," Senator Zaffirini said. "We need the ethical people coming to work with us the way TMA did in developing that legislation [last] summer."

Mr Ross said lawmakers need to consider admission policies and procedures. And, he said current prohibitions in the Medical Practice Act that regulate unethical practices by physicians should be applied across-the-board to other licensed health-care professionals as they go through the sunset review process in 1993. Those include prohibitions against fee-splitting and sanctions for persistent and flagrant overcharging and overtreating.

The interim committee is scheduled to continue its hearings through March. Though locations had not been finalized, Senator Zaffirini expected hearings to be held in Laredo, El Paso, Lubbock, and Corpus Christi or the Rio Grande Valley.

Following the hearings, the panel will organize into a work group to begin drafting legislation.

[Note: See "Texas illegal remuneration statute builds on previous law," p 68, for information on just what the law passed last summer covers.]

[Editor's note: Swamped by complaints against private psychiatric hospitals it licenses, the Texas Department of Mental Health and Mental Retardation, at Texas Medicine *press time, issued emergency rules to protect the rights of patients. The rules can remain in effect for 120 days before MHMR must act to make them permanent.]*

Medical waste, indigent care among legislative studies set for 1992

WHILE SENATE HEARINGS on problems at psychiatric hospitals and the governor's newly appointed health-care task force might grab most of the media attention this year, House committees are gearing up to study a wide range of health issues, including medical waste disposal, indigent health care provided along the Texas-Mexico border, and maternal and child health-care services.

House Speaker Gib Lewis has instructed 29 House committees to study 150 issue areas for possible legislation when the 73rd Legislature convenes in 1993. Both the House Committee on Public Health and Committee on Human Services have a full slate of charges from the speaker.

"The increasing complexity of the problems facing our state and the expanding needs of our citizens require that the work of the legislature continue in the interim between sessions," Speaker Lewis said.

The committees have been asked to issue their reports and submit draft legislation by November 1.

The following are the charges to the Public Health and Human Services committees:

Committee on Public Health

- Study medical waste disposal in coordination with the Committee on Environmental Affairs.
- Study health-care reimbursement, and coordinate with and monitor the Texas Health Policy Task Force as it relates to this issue.
- Study the administration of medication in hospitals, nursing homes, and extended care facilities.
- Study the problems associated with indigent health care provided to the citizens of Mexico in the border regions of Texas.
- Study tuberculosis testing, treatment, and control.
- Study the reporting of childhood lead poisoning.
- Study the adoption of an enforceable lead ban.
- Study oral health in long-term care facilities.
- Study chronic disease prevention by instituting dietary changes in publicly funded food services.

Committee on Human Services

- Study inappropriate admissions and dismissals of adolescents to psychiatric hospitals (in coordination with the Committee on Insurance's study of effects of mental health insurance).
- Study the implementation of the Pre-admissions Screening and Annual Resident Review, including the areas of program design, Alternate Disposition Plan, accountability, and residents' rights and training.
- Study electronic benefits transfer.
- Study the improvement of maternal and child health-care services, including maximizing federal funds, removing barriers to services, and exploring methods of creating a coordinated system of services to eligible pregnant women and children.
- Monitor child protective services in the proposed structure of the Department of Protective and Regulatory Services including criteria

used in "priority" classifications and intervention methods and response time per classification; services provided to children over the age of 10 and to special needs children; value of family preservation services; and problems associated with abused or neglected children in one-parent homes.

- Study health care in women's correctional facilities.
- Monitor and coordinate with the Texas Health Policy Task Force as it relates to trauma care in Texas.

Governor's task force ready to launch access to care study

A "CAREFUL, THOUGHTFUL, AND well-balanced" approach to addressing the state's health insurance and access to health care problems is what Texas Medical Association is expecting from the Texas Health Policy Task Force.

Governor Ann Richards announced creation of the long-awaited task force November 13 and named Shirley S. Chater, president of Texas Woman's University in Denton, to chair the panel. Governor Richards initially promised to appoint the task force last summer and to call a special session in 1992 to deal with health care. She later decided to hold the issue until the next regular session of the legislature in 1993.

The panel includes 14 public members appointed by the governor, six members of the Texas Senate appointed by Lt Gov Bob Bullock and six House members appointed by Speaker Gib Lewis. Medicine is represented on the task force by Richard Barry, MD, of Odessa. Dr Barry is a professor of family medicine and assistant dean for clinical affairs at the Texas Tech University Regional Academic Health Center in Odessa. He also is a founding member of the Coalition for Rural Health.

In her executive order creating the committee, the governor charged the group with defining what basic health care is and outlining what Texas can do to enhance preventive and primary care. She also asked the committee to propose a basic health insurance benefits package, a range of health insurance options for business, and cost-saving measures. The final charge was to recommend ways to coordinate the health-care delivery system with special emphasis on rural health services and trauma care.

> "THE GOVERNOR'S MAKING ALL THE RIGHT MOVES . . . TMA AND TEXAS PHYSICIANS WILL BE AN INTEGRAL PART OF THIS EFFORT."

Those charges focus on the same issues addressed last year by TMA's Ad Hoc Committee on Financing and Availability of Health Insurance. That committee's report, which recommended a five-point plan including a basic group health policy, is expected to be the springboard for the work of the new task force.

"It (the executive order) picks up where the TMA ad hoc committee left off and charges the task force with the same objectives," said Fred Castrow, MD, chairman of the TMA Council on Legislation. "So, a lot of the homework, the groundwork, the consensus building already have been achieved."

Dr Castrow said TMA is pleased with the quality of the people and the expertise that's going to be available.

"The governor's making all the right moves," he said. "She's showing a determined interest in fairness and balance and a mental toughness about making some difficult choices. TMA and Texas physicians will be an integral part of this effort."

Other members of the task force include Sue Iha, a registered nurse from Houston; Lois Moore, president of the Harris County Hospital District; Linda Chavez-Thompson of San Antonio, a leader of the American Federation of State, County and Municipal Employees; Ben Cook, a retired Bullard businessman who serves on the American Association of Retired Persons' state legislative committee; Peggy Smith, head of the Teen Health Clinic in Houston; Levy Curry, executive vice president of administration and human resources at American Federal Bank in Dallas; Larry Milner of Austin, president of the Texas State Chamber of Commerce; Tommy Jacks, an Austin trial lawyer; Mary Ellen Schattman, director of governmental relations for the Tarrant County Hospital District; Joe Phillips of McAllen, owner of a gas marketing company; and Bill Daves of Dallas, former chairman of the State Board of Insurance.

Senate members include Senators Chet Brooks of Pasadena, Eddie Lucio of Brownsville, Mike Moncrief of Fort Worth, Carl Parker of Port Arthur, Peggy Rosson of El Paso, and David Sibley of Waco.

House members include Representatives Clyde Alexander of Athens, Eddie Cavazos of Corpus Christi, Wilhelmina Delco of Austin, Nancy McDonald of El Paso, Jim Tallas of Sugar Land, and Bob Turner of Coleman. ★

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Public Health

Delegates maintain stand on HIV-infected physicians

REFUSING TO BOW TO NATIONAL hysteria surrounding exposure-prone invasive procedures, the Texas Medical Association House of Delegates rejected recommendations to amend the association's guidelines for HIV-infected health-care workers.

The recommendations were presented by the TMA Board of Councilors; modified recommendations were made by the Reference Committee on Public Health and Scientific Affairs during the interim session held November 15–16 in Austin. The House decision reaffirmed current TMA policy approved in May 1990 with referral to the Board of Councilors for continued study (see sidebar).

"The message being sent by the House of Delegates is that decisions involving HIV-testing of physicians should be based on scientific fact," said Catherine Edwards, PhD, director of the TMA public health and scientific affairs department. "This has not occurred on the national level."

The reference committee had sought the following additions to the guidelines:

- An infected health care worker shall not perform exposure-prone invasive procedures unless the health care worker has sought counsel from [a] special committee and been advised under what circumstances, if any, the health care worker may continue to perform the exposure-prone procedures.
- An infected health care worker may not perform an exposure-prone invasive procedure without first notifying the patient of the health care worker's seropositive status and obtaining the patient's consent to such procedure before the patient undergoes the procedure.

In a report to the House of Delegates, the Board of Councilors cited, "although public concern over the problem of HIV infected health care workers has been largely driven by the case of Dr David Acer, a Florida dentist who died of AIDS, scientific

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

TMA POLICY ON HIV-POSITIVE PHYSICIANS

THE FOLLOWING GUIDELINES were approved by the TMA House of Delegates as official policy in May 1990. These guidelines should be provided to physicians who test positive for HIV:

(a) A health care worker who performs invasive procedures and has reasonable cause to believe he/she is infected with HIV should determine his/her serostatus or act as if that serostatus is positive.

(b) If an infected health care worker performs invasive medical procedures as part of his/her duties, the health care worker should request that an ad hoc committee be constituted to consider which activities the infected health care worker can continue to engage in without risk of infection to patients. Membership of this committee may be composed of, but not necessarily limited to, an infectious disease specialist familiar with HIV transmission risks, the pertinent hospital department chairperson, a hospital administrator, the infected health care worker's personal physician, and the infected health care worker.

(c) A confidential review system should also be established by the ad hoc committee to monitor the health care worker's fitness to engage in invasive health care activities. Any restrictions or modifications to health care activities for patient safety should be determined by the ad hoc committee based on current medical and scientific information.

(d) Knowledge of the health care worker's HIV status should be restricted to those few professionals who have a need to know. Except for those with a need to know, all information on the serostatus of the health care worker should be held in the strictest confidence.

(e) As a general rule or until there is scientific information to the contrary, the health care worker should be permitted to provide health care services as long as there is no identifiable risk of patient infection and no compromise in physical or mental ability of the health care worker to perform the health care procedures.

(f) Where restrictions, limitations, modifications, or a change in health care activities are recommended, the ad hoc committee should do its utmost to assist the health care worker to obtain financial and social support for these changes.

(g) If intra-institutional confidentiality cannot be assured, health care facilities should make arrangements with other organizations such as local or state medical societies to serve the functions of the ad hoc committee.

evidence does not support the widespread public concern."

Other action taken by the delegates on recommendations and resolutions concerning HIV/AIDS included:

- approval of a recommendation asking the Texas Department of Health to make mandatory the reporting by name of confirmed HIV-positive tests by laboratories along with legal protection of confidentiality;
- approval of a resolution to support adequate funding and implementation of public health measures to help stop the spread of HIV/AIDS, that all individuals who know they are HIV-positive notify health-care workers of their HIV-positive status when contact with them could result in transmission of the HIV virus, that physicians be allowed to order testing for HIV on patients they have reason to believe might be positive or who are scheduled for procedures where there is risk of transmission of HIV to the physician or others (approved with referral to Council on Legislation) and submission of a resolution to American Medical Association House of Delegates;
- referral to the Committee on Blood Banking and Blood Transfusion of a resolution calling for Congress to expand the National Vaccine Injury Compensation Program to incorporate the limited group of AIDS patients who acquired the infection as a result of medical therapy; and
- amendment of a recommendation from the Medical Students Section concerning legal status of medical students under the AIDS Omnibus Bill of 1989. The recommendation calls for the TMA general counsel to determine if the definition of "health care workers" in the bill includes students in training and educational programs. If covered, TMA will notify all hospitals; if they are not covered, TMA will seek to amend legislation so they are included.

Teen sexuality report garners favorable response

AN ALARMING REPORT ON adolescent sexual activity, which reveals Texas leads the nation in teen pregnancy rates in females aged 14 and under, was approved by the TMA House of Delegates during the interim session held November 15–16.

The House also approved an amended recommendation to "actively support and lobby for legislation which would direct the State Board of Education to include comprehensive education on both human sexuality and family life as part of the mandated health education curriculum in Texas schools."

The adolescent sexual activity study, produced by the Adolescent Health Task Force, outlines the risks adolescents are facing in the areas of pregnancy, contraceptives, and sexually transmitted diseases.

"We need to remember adolescents are important people and we need to be taking care of them," said James C. Hoyle, Jr, MD, chairman of TMA's Adolescent Health Task Force.

Dr Hoyle said the report is a general guideline that serves as an overview of what the task force would like to see happen in the areas of education and legislative action as it relates to adolescent health problems.

Enlisting the support of the Texas legislature and Texas Education Agency will form a partnership that is "just unbeatable," said Dr Hoyle.

Included in the report are principles outlining the roles of physicians and the Texas Medical Association in responding to adolescent health issues. The delegates also approved the legislative initiatives in the report and referred them to the Council on Legislation.

The role of the physician is to:

- provide sexuality education;
- become familiar with confidentiality and consent laws;
- counsel teenagers on contraceptives;
- identify teenagers at risk of STDs and unplanned pregnancy through medical/life-style histories;
- review sexual decision-making implications based on self-esteem;
- discuss sexual responsibility without moral judgments; and
- treat and counsel adolescent patients with respect to sexual development, sexually transmitted disease, birth control, and pregnancy.

For additional information on the report see "Health risks of adolescent sexual activity are focus of TMA report," *Texas Medicine*, November 1991, pp 60–61.

Border health commission, other public health topics win delegates' support

TO MEET THE CHALLENGE OF serious health and environmental problems along the US-Mexico border, the TMA House of Delegates approved a resolution calling for legislation to establish a US-Mexico Health and Environ-

mental Commission.

The resolution, passed during the interim session held November 15–16, directs TMA to ask the American Medical Association to draft and introduce legislation in 1992 to enact the establishment and funding of the commission.

"Issues pertaining to the health and environment along the US-Mexico border have been thoroughly studied," said Catherine Edwards, PhD, director of the TMA public health and scientific affairs department. "The time for action on these problems is now." (See "TMA leads push for border health commission," next page).

In other action taken on recommendations and resolutions presented by the Reference Committee on Public Health and Scientific Affairs, the delegates:

- pointed out that the term "health-care provider" is a generic term that does not communicate the emphasis on education and concern for patients embodied by the traditional terms "physician" or "doctor";
- supported the legal availability of the antiprogesterone steroid RU 486 (mifepristone) for appropriate research and, if indicated, clinical practice (In addition to its use in terminating early pregnancy, RU 486 is also under clinical investigation for treatment of breast cancer, Cushing's syndrome, endometriosis, and difficult deliveries.);
- established a policy stating that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services;
- called for the distribution of state-of-the-art cholera information to physicians and to primary care residency programs in Texas;
- called for legislation to require that all new cars be equipped with air bags and shoulder belts in the front seat;
- supported educating the public and publicizing current law and dangers of transporting people in backs of pick-up trucks;
- approved a recommendation that, when generic substitutions are made, the prescription label on the container show the brand name of the generic substitution;
- urged physicians to offer pneumococcal immunizations to patients age 65 and over; and
- called for legislation to allow 17-year-olds to donate blood without parental consent.

AGENDA ON AIDS

CDC lingering on release of procedures list

The wait continues for the Centers for Disease Control list of exposure-prone procedures that should not be performed by HIV-infected physicians. At press time, the CDC had not released the list, which was originally scheduled to be published November 15, 1991, in *Morbidity and Mortality Weekly Report*. Testimony on the proposed list was presented to the CDC at a hearing in November. According to the CDC, the guidelines are being reassessed and no date has been announced for release of the final document. The list is part of the CDC's guidelines to prevent transmission of HIV from health-care workers to patients.

Staff cuts won't hinder education for addicts

Street addicts will continue to be educated about the dangers of AIDS even though a budget slash has resulted in the cutback of six employees in the HIV Division of the Texas Commission on Alcohol and Drug Abuse. Bill Britcher, TCADA information officer, says the agency will offer educational services to outreach clinics through a private contract. "All that has changed is we are going outside the agency and not providing the services with our own staff," says Mr Britcher.

Sources for Agenda on AIDS are the TMA Public Health and Scientific Affairs Department, Texas Commission on Alcohol and Drug Abuse, and the Centers for Disease Control.

Four Texas counties part of national health survey

A NATIONAL SURVEY TO EXPLORE the health and nutritional status of Americans will include selected residents of four Texas counties.

The National Health and Nutrition Examination Survey III (NHANES III) will be conducted in Dallas, LaSalle, Hopkins, and Travis counties through May 1992. Information gathered from the survey will be used to determine health-care needs of children and adults.

Personnel will conduct interviews on the following schedule:

- Dallas County: December 11, 1991, through February 29.
- LaSalle County: January 17 through March 20.
- Hopkins County: February 7 through April 4.
- Travis County: February 27 through May 8.

The study, sponsored by the National Center for Health Statistics, will involve 1,830 Texans aged 2 months and older. Approximately

40,000 individuals will take part in the national study.

Physical examinations, body measurements, and dietary interviews will be conducted in a specially-equipped mobile unit by the survey team, which consists of a physician, dentist, medical and health technicians, and dietary and health interviewers.

Data collected will be used to study heart disease, asthma, chronic bronchitis, kidney disease, gallbladder disease, osteoporosis, arthritis, infectious diseases, dental caries, periodontal disease, allergies, depression, hearing loss, vision problems, iron deficiency anemia, and obesity.

Information about the survey is available from the Scientific and Technical Information Branch, National Center for Health Statistics, Room 1064, 6525 Belcrest Rd, Hyattsville, MD 20782, (301) 436-8500.

TMA leads push for border health commission

Ken Ortolon
Legislative Affairs Editor

Medical associations from the four states that border Mexico, led by Texas Medical Association, have joined forces with the American Medical Association to push for creation of a binational commission to address public health and environmental problems on the US-Mexico border.

The TMA House of Delegates, at its interim session in Austin November 16, adopted a resolution calling on the AMA to draft and introduce in Congress legislation to create the US-Mexico Health and Environment Commission. The resolution came out of a work group session held during TMA's Third Annual Border Health Conference, held in McAllen on October 25–26, and was sponsored by the Hidalgo-Starr County Medical Society. It was to be presented to the AMA House of Delegates in December, where it was expected to pass easily.

During the McAllen conference, representatives of state medical associations in New Mexico, Arizona, and California agreed to support the resolution at the AMA House of Delegates. AMA officials also had already agreed to assist in drafting and lobbying for the commission.

"Health and environmental conditions along the US-Mexico border seriously threaten those living in the region," the resolution states. "These conditions include fecally contaminated ground water and river water that spawns infectious diseases at rates two to seven times the national average; communicable infectious disease rates that are higher than the national average; and air and water quality that are compromised by toxic emissions and hazardous waste."

Tens of thousands of people throughout the border region live in substandard housing developments called *colonias*. Many of these *colonias* lack potable water and adequate sewage treatment. Those and other factors put *colonia* residents at risk for a wide range of infectious diseases. Diseases that occur in the border area at rates significantly above national averages include hepatitis, tuberculosis, malaria, and leprosy. The area also is at risk for cholera, which is spreading north from South America and Mexico.

Physicians, public health officials, government officials, and industry representatives who participated in the Border Health Conference agreed that health and environmental problems on the border must be addressed now if the anticipated North American Free-Trade Agreement is to be successful in improving economic conditions in the region.

"This (free-trade) agreement has the potential to generate tremendous opportunities in the region," TMA President Sam A. Nixon, MD, told conference participants. "It will bring jobs to Mexico, create jobs, generate revenue . . . But it also has the potential to destroy our border if the desire for economic prosperity is not preceded by sound health and environmental safeguards. Very simply, sick workers are not productive workers."

Laurance N. Nickey, MD, of El Paso, chairman of TMA's Council on Public Health, said the joint commission is vital because one nation working alone cannot correct conditions that exist on both sides of the border.

The proposed border commission would be patterned after a similar binational effort that took place in the 1960s and early 1970s. That project helped build wastewater treatment plants, carried out rabies control, and conducted public health research.

TMA launched its efforts to address border health problems in 1989 when it hosted the First Annual Border Health Conference in El Paso. A second conference was hosted last year by the California Medical Association.

In addition to the call for a border health commission, participants at the October conference studied possible funding sources for border health programs and identified needed research in the area. Among suggestions for funding of border health initiatives was use of money seized from convicted drug dealers. Liver and cervical cancer were among potential research topics identified. ★

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under siege:

THE *Embattled Trauma Care System*

IT IS THE HALLMARK of every emergency room: that atmosphere of urgency, a feeling heightened by the drama of the moment. The drama of an emergency room standoff between rival gangs, as doctors battle to save yet another young gunshot victim. The horror of the broken body of a wandering pedestrian found crumbled in a spreading pool of his own blood in the middle of a major city freeway. The pathetic cries of a child for his absent mother after he was struck down in an innocent moment's joy as he ran after a candy truck. But the underlying tapestry of the emergency room, beyond the headline horror of the day, is the sense of time being gnawed away in small incremental pieces, tiny moments of individual crisis.

The emergency centers in Texas and the nation are places where the clocks, as the poet Dryden wrote, are being worn out from eating time. In the hallways and waiting rooms with their stark, fluorescent lights and uncomfortable chairs, time is being consumed by a growing crisis that threatens to tumble the emergency and trauma care system in Texas. If there is system failure, emergency physicians warn, there will be profound repercussions for the whole health-care network in the state.

The trauma care system itself in

By Hilary Hylton

ARY HYLTON IS AN AUSTIN-BASED FREE-LANCE WRITER.

INTO Texas emergency rooms, *particularly those designated as* major trauma centers *and usually funded by* PUBLIC *or* PHILANTHROPIC MONIES, *pour the* uninsured, *the* underinsured, *the* desperate, *the* socially maladjusted, *the* ignorant, *the* old, *and the* injured.

Texas is critically injured, according to a recent report ordered by the Texas legislature: "The health care institutions we count on to make up a trauma system are suffering significant morbidity due to uncompensated and undercompensated care — much of it traceable to the treatment of trauma patients. We will all suffer if these institutions' 'injuries' cannot be healed," concluded the Texas Department of Health report, titled "Texas Trauma," released in late 1990.

Uncompensated care is a major cause of the crisis in Texas, but it is just one element. There is also a lack of facilities, a reluctance by some to participate in an unfunded trauma network, mounting paperwork, the AIDS and hepatitis B epidemics, a lack of emergency medicine residency programs, geographic distance and isolation, geriatric dumping, escalating violence, ignorance, poverty, physician burnout, liability exposure, and a lack of political leadership.

But while the complexities of the trauma care crisis compound, there is always the emergency of the moment for the doctors and nurses, technicians and paramedics. Their time is measured in both tedious and tense ways. They spend long, monotonous hours offering primary care — the sort of advice and solutions meant to be dispensed elsewhere — to the poor, the under-educated, the culturally alienated, the forgotten, the drunks, the drug addicts, the young and the old. And they are called on in critical moments where time is measured in seconds, seconds that make up that first "golden" hour in which a trauma patient has a significant chance of survival if he or she receives the best care.

In the popular press, the nation's emergency centers are portrayed as war zones, as often they are — a 2-hour standoff between rival gangs took place last summer at Methodist Hospital in Dallas. But the battle is not just the obvious, headline-grabbing story of the moment. This is escalating, relentless trench warfare. Into Texas emergency rooms, particularly those designated as major trauma centers and usually funded by public or philanthropic monies, pour the uninsured, the underinsured, the desperate, the socially maladjusted, the ignorant, the old, and the injured. If system failure comes, it may not be with a headline-grabbing bang.

"Everybody expects this cataclysmic phenomenon to occur when the system breaks down. Of course, that's not how it happens. When you have system failure it comes like a thief in the night," says F. David Prentice, MD, chairman of the Texas Medical Association's Committee on Emergency Medical Services and Trauma and director of emergency medicine for the Memorial Healthcare System in Houston.

And what happens if the system fails, Dr Prentice asks rhetorically. The traumatically injured from all walks of life and segments of society will suffer, he says. "If John Q. Public can't get to Ben Taub and he is taken to emergency room A, where it takes 3 hours to operate instead of 1, he may die of kidney or respiratory failure 7 or 8 days later. No one will pick up on that because the death certificate will simply say 'complications from severe injury,' but this may have been a preventable death."

Death rates from trauma soar when patients are taken to nontrauma center hospitals. "Preventable death rates for a Level I trauma center probably run about 2% to 3%, meaning that everybody who arrives with an injury who potentially is salvageable will be saved except for 2% to 3% of patients," Dr Prentice says. "But, if you take patients with critical injuries to nontrauma center hospitals, then preventable death rates soar into the 40% to 50% range, perhaps even higher."

Both Ben Taub Hospital in Houston and Parkland Memorial Hospital in Dallas were forced during the summer of 1991 to go on "drive by" status. Ambulances carrying severely injured patients were diverted to backup facilities. Writing to Gov Ann Richards at the peak of the

1991 summer crisis, Ron Anderson, MD, chief of Parkland and chairman of the board of Texas Department of Health, described the trauma system in Dallas and Houston as being "tenuously held together."

Activity at Hermann Hospital's trauma facility has been restricted to treating only Lifeflight trauma patients, an action taken, in large part, because of the crippling economic burden of uncompensated care. Houston, a city of 3.2 million, now has only one Level I facility, Ben Taub. The accepted standard, recommended by the American College of Surgeon's Committee on Trauma, is a minimum of one Level I trauma facility per million population.

The growing burden of trauma care

"LAST YEAR there were 358,200 injuries in Texas, and trauma was the leading cause of death from 0-44 years of age," Dr Anderson wrote. "Trauma is still the leading cause of death, even in the face of the AIDS epidemic, and is the leading reason for lost man years production in our state and nation. We have seen roughly a 25-30% increase in serious penetrating trauma related to drug and gang related violence in the Dallas and Houston areas. This increase in absolute numbers of cases and a shift in those cases to the few hospitals that will receive them result in a disproportionate load and threat of collapse of the 'trauma systems' in these cities that functioned so well for so long."

This escalating violence has become a major concern for the 690 emergency medicine specialists in Texas, according to Kathryn Dykgraaf, executive director of the Texas chapter of the American College of Emergency Physicians and a TMA consultant on EMS/trauma care. Much of it is drug-induced, and emergency physicians find themselves often working in bizarre situations. Burnout has become a buzzword in emergency medicine circles, particularly as doctors face ever increasing numbers of patients on a daily basis and must often evaluate patients who are high on crack cocaine, a drug that seems to induce violence, or drunk, or infected with HIV or hepatitis B.

"The firepower is out there," says Dr Anderson, "and people settle their disputes with guns now. It used to be when you got shot, about 5% of the time they shot you several times and now it's about 30% of the time we see multiple gunshot wounds." As *Texas Medicine* reported last November, deaths from gunshot wounds surpassed automobile accident-related deaths in 1990 in Texas, the only state to report crossing that threshold, according to the Centers for Disease Control.

The increase in so-called penetrating trauma, caused by guns and knives, is reflected at the national level also. A May 1991 report by the US General Accounting Office, concluded that penetrating trauma "represents a growing share of urban trauma injuries." Not only has the number of gunshot wounds increased, but also their intensity, as Dr Anderson noted. The GAO report found that increased use of semiautomatic weapons had complicated penetrating trauma injuries. In 1989, while Beirut, Lebanon, was torn by internecine strife, Los Angeles actually treated more victims of automatic weapons, according to *Time* magazine.

The violence is not limited to urban areas. William L. Moore, MD, a Tyler physician and emergency medical services director for the East Texas Medical Center and its affiliated hospitals, reports he is seeing more cases of penetrating injuries in small town and rural Texas.

On a recent Sunday morning Dr Moore treated a young man with 19 deep lacerations on his head and face, all at least 1-inch long. They had been inflicted by his brother wielding a broken gin bottle. Both young men had been high on crack cocaine and had been drinking. "Emergency rooms across our state are the focus point for what is happening in society in general," says

"Stop the Bleeding"

Trauma prevention education campaign

TRAUMA IS A DISEASE of the young and in Harris County it has reached epidemic proportions with a rate 67% higher than the national norm in 1990. Hence the campaign launched by the Harris County Medical Society to battle escalating trauma injuries and deaths among young people. The campaign is similar to one to be launched by the Texas Medical Association in 1992.

Dubbed "Stop the Bleeding," the campaign focuses primarily on the schools, using classroom videos and materials. The campaign also features a speakers' bureau and calls on the local media to produce public service announcements, documentaries, talk shows, and feature articles. Traffic law offenders also are required to view an injury prevention documentary.

"We have an injury epidemic in Harris County," says Arthur Jansa, MD, president of the Harris County Medical Society, "and no one is immune. Each one of us is at risk. The effects of this epidemic are seen in every hospital emergency room."

The Harris County campaign was initiated in response to a 3-year dramatic rise in all types of injury deaths and the recommendations of the Trauma Care Commission. In 1990, the county's death rate was 51% higher than predicted for a comparable urban area. It was predicted 1,276 persons would die from injury that year in Harris County — the actual number was 1,933. While 580 died from motor vehicle injuries, 773 died from gunshot wounds and 135 from stabbings.

The economic impact on Harris County also has been staggering:

- $152 million in acute medical care costs alone;
- $800 million in loss of future earnings each year as a result of death due to injury; and
- $2.3 billion in total economic impact each year due to injury.

"Emergency rooms *across our* state *are the* focus point *for what is* HAPPENING *in* SOCIETY *in general."*

Dr Moore, who serves on TMA's EMS and trauma care committee. "We see as much bad trauma as Ben Taub and Parkland, at a much slower rate, but with the same severity."

The same is true for the presence of AIDS in the emergency center. "People who have AIDS are coming home to die," Dr Moore says. "They are coming to spend their last days with their parents, and we are seeing them in emergency rooms in rural areas."

Dr Moore said his fellow emergency physicians practicing in rural areas also see terrible examples of trauma caused by alcohol-related automobile accidents. Even though Tyler is located in a dry county, Dr Moore said he is constantly treating blunt trauma caused in accidents where alcohol was a major factor. No part of the state is immune from these social ills, he says.

Victims of violent trauma often uninsured

THIS INCREASE in violent trauma not only strains and drains the physical resources of a trauma center, it is more likely to result in large unpaid or underpaid bills. The average charge per hospital admission for a trauma patient is three times higher than that for a regular acute care admission and the lack of insurance is most common among those 45 and under — the population group most likely to be the victims of penetrating trauma. According to the GAO, in 1988 about 80% of the gunshot and stabbing victims treated in the urban centers studied were uninsured or ineligible for federal medical care cost assistance.

Because there is no Texas data base breaking down trauma by category (one is planned under proposed rules now being reviewed by the TDH), it is difficult to arrive at a percentage for unreimbursed versus reimbursed costs for penetrating trauma. However, the population of Texas is young and growing. According to US Census figures, Texas is the youngest of the 10 most populous states. Recent estimates have pegged the number of uninsured Texans at between 17% and 22% of the population. There is an added factor in the Texas picture — Medicaid eligibility in Texas is said to include only one third of the state's poor.

Another facet of the reimbursement issue is that, in Texas, it is usually unlikely for a patient without a funding source to receive rehabilitation. The TDH study reported that objective data were scarce, but verbal reports suggested rehabilitation was not an option for uninsured patients. Of 1,601 head injury patients, only 3% of the rehabilitation care went uncompensated. That raises another issue — the years of potential life lost due to trauma. Given the number of lives lost due to trauma in 1989, the TDH study concluded that 291,218 years of potential life were lost. The comptroller of accounts says the state will lose some $221 million in lifetime revenues from just the 1989 victims of trauma.

The TDH study also concluded the annual cost of uncompensated trauma care in Texas is approximately $213.5 million and that does not include physicians' costs, estimated to be an additional $24 million. Large, metropolitan government-owned teaching hospitals provide an average of $8.4 million in annual uncompensated trauma care. Private teaching hospitals provide an annual average of $2.5 million in uncompensated trauma care. Trauma hospitals located in cities with populations between 100,000 and 300,000 provide $1.7 million annually.

Not only are the odds higher that a trauma patient will be uninsured or underinsured in Texas, but recent data also indicate that patients with lower socioeconomic status are more likely to use the emergency department as their means of access to a hospital. (Emergency department services are currently included in the definition of primary care for the

urposes of the Medicare Economic ndex Update — recognition by Congress that they provide primary are to a substantial number of Americans.) A study published in the October issue of the *Journal of American Medicine* tracked 20,000 patients admitted to five Massachusetts hospitals for 6 months. The authors concluded that "hospitals that make emergency department services more available may be more likely to hospitalize socioeconomically disadvantaged patients and may be at a substantial financial disadvantage under per-case reimbursement systems such as Medicare."

All these pressures combine to have a domino effect on the hospital's overall service. At Parkland, for example, Dr Anderson said routine surgery is being canceled on Monday mornings to help the hospital and staff recover from the weekend barrage in the emergency center. The GAO study found in the 35 trauma centers it studied that surgeries, x-rays, and CT scans for nontrauma patients were being postponed and rescheduled to accommodate trauma patients' urgent care needs. In addition, trauma patients were occupying needed ICU beds.

The domino effect doesn't stop there. When a trauma center closes — and of the 35 reviewed by GAO, 15 closed, 12 primarily from financial loss — the patients and accompanying financial losses are carried to centers that remain open. "The domino effect can deteriorate trauma systems to the point of failure," the GAO study concluded. A deteriorating payer mix leads to increased financial losses, a shifting of uninsured and underinsured to another strained facility, and that can lead, in turn, to systemwide failure.

AT Parkland, *routine surgery is being* canceled *on* MONDAY MORNINGS *to* HELP THE HOSPITAL AND STAFF recover *from the* weekend barrage *in the* emergency center.

Signs of future problems

"THE WHOLE system is breaking," says Dighton C. Packard, MD, medical director for emergency services at Baylor University Medical Center, which operates emergency centers in Dallas, and North and East Texas. "We have more sick people than there are physicians capable of dealing with them," he says, noting that public and nonprofit hospitals are bearing the burden. For example, in Los Angeles where the trauma care system is in crisis, some private hospitals have simply changed the name of their emergency centers and open them only to paying patients, he says, bypassing the federal law mandating that emergency centers are open to all.

"My main concern is that it seems to me the first thing we did was disenfranchise the poor. They can only go to Parkland or come to us. We have disenfranchised the Medicaid population . . . the next disenfranchised group will be Medicare . . . I am sitting here looking at a chart of an 81-year-old lady who has a broken hip, hypertension, heart disease, and she doesn't have a doctor. She has outlived her doctor and can't find one to take her."

Geriatric dumping is now going on at the nation's emergency centers. On a recent Friday night, the medicine emergency room at Parkland was overflowing primarily with geriatric cases. The medicine ICU unit was on "yellow status" — full and unable to take any more cases. Some of the indigent patients had been waiting in the emergency center for 4 to 5 days for a room to be found at a neighboring hospital willing to take them.

Again, this is not just an urban problem. Jamie Ferrell, RN, director of emergency services at Northwest Texas Hospital in Amarillo and president of the Texas Emergency Nurses' Association, says the problem of geriatric dumping is especially acute in those emergency centers serving rural Texas. As the rural population ages, more elderly Texans who have exhausted their resources and their family's ability to cope are being left in emergency centers. They are one more pressure on a system already at the straining point because of the trauma care crisis.

Tying the safety net together

The proposed statewide trauma system rules

THERE IS NO STATEWIDE TRAUMA SYSTEM in place in Texas. Through grassroots efforts some sections of the state have developed their own "system." Other regions have no system in place.

House Bill 18, passed in 1989 by the Texas legislature, mandated the development and adoption of statewide EMS and trauma system rules. Last summer, the Trauma Technical Advisory Committee to the Texas Department of Health developed a set of rules that likely will be heard by the TDH board this month. During hearings on the rules, Dr Ron Anderson, chief of Parkland Memorial Hospital in Dallas and chairman of the TDH board, urged that the rules be adopted despite the fact that no funding is in place for implementation. He said the current "system" of trauma care is "being held together with a little bit of glue and a lot of goodwill . . . We need to tie the safety net together and it's important that we be together on this."

Gene Weatherall, chief of the Bureau of Emergency Management at the Texas Department of Health, says while everyone involved in the process is concerned about funding, it is vital that a framework be put in place now. A characteristic of the proposed system is its voluntary nature. "We looked at a lot of different states — California, Florida, Oregon — and we took the best from each," Mr Weatherall says. "We found the reason they failed, especially in California and Florida, was they didn't set aside any money for a trauma system, but they mandated designation of certain hospitals as trauma facilities. The hospitals in the process went broke."

Where systems have developed in the state at the grassroots level, Mr Weatherall says, the participation and compliance has been good, hence he has no concerns about making the system voluntary. Plus, the new rules call for local and regional control and input from health-care professionals and local citizens.

One crucial element in the new rules is the establishment of a statewide data base on trauma — the number and type of injuries, costs, outcomes, etc — that will serve as a powerful tool, according to Mr Weatherall in both combating the problem and addressing funding needs at the local and legislative level.

Here is an overview of the proposed system rules:

The state will be divided by county boundaries into 22 Trauma Service Areas (TSAs). A voluntary regional advisory council, dubbed a RAC, must oversee the TSA in order for it to be part of the statewide EMS/trauma system. RACs may request assistance from the Bureau of Emergency Management, but they will not receive any state funding.

All "participating health-care entities" will be represented on the RAC. For the first 6 months, hospitals will be granted provisional membership on the RAC, but in order to continue as a member, a hospital must make a commitment to trauma care.

Each RAC is charged with developing a system plan based on standard guidelines, and the system must be approved by the Bureau of Emergency Management. The plan should address medical oversight, prehospital triage criteria, diversion policies, bypass protocols, regional medical control, facility triage criteria, interhospital transfer, planning for the designation of trauma facilities, and quality management program for the system.

The rules also call for the Bureau of Emergency Management to designate trauma facilities statewide (Level I, II, III, and IV) based on TDH rules in place. Following the submission of an application that shows, among other things, the hospital's role in system planning, a survey will be conducted by either the American College of Surgeons or an approved alternate team. After September 1993, no hospital may use the term trauma facility, hospital, or center unless it has been designated a trauma facility under the rules. The rules also provide for a complaint procedure and denial, suspension, and revocation of trauma facility designation.

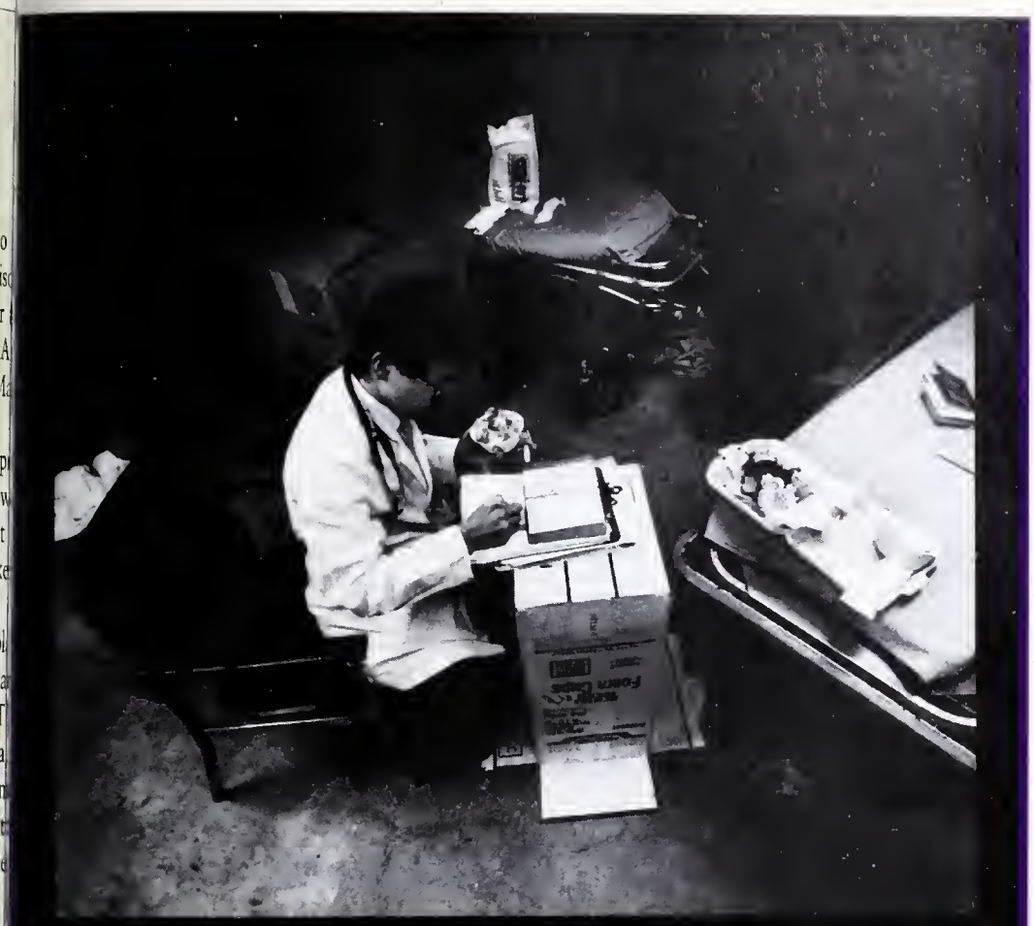
Finally, the rules establish a statewide trauma registry to identify major or severe trauma patients within each "health care entity" in the state, identify the total amount of uncompensated trauma care, and monitor patient care and regional EMS/trauma system services. This trauma data will be submitted on a quarterly basis to the registry by August 31, 1996.

The threadbare patchwork

IN THE 26-COUNTY area served by Northwest Texas Hospital there is one trauma center with its 24-hour emergency room and only one minor emergency clinic that operates for just 12 hours a day. Headline-making, urban innovations are impossible, Ms Ferrell says, due to limited resources: "I get frustrated when doctors come into our meetings and wave *Newsweek* around and say some urban hospital is triaging non-urgent patients to a clinic. We have no options here."

Perhaps ironically, that lack of resources and options is credited with making rural Texans and particularly rural physicians more aware of the need for a trauma care system, according to Ms Ferrell and Donald J. Gordon, MD, PhD, an emergency physician who serves as medical director to the San Antonio EMS and is chairman of the department of emergency medical technology at The University of Texas Health Science Center at San Antonio. They operate in two regions of the state that have some semblance of a trauma system in place — the 6,000 square mile East Texas system headquartered in Tyler and the 26-county West Texas system with Amarillo as its hub.

The concept of a trauma care system evolved out of both military needs in wartime and advances in



"Hospitals *do a* valiant job *to* PROVIDE *a* SAFETY NET, *but it's not* sewn together WELL ENOUGH."

medicine. The system reached a level of refinement during the Vietnam War and then was adapted to serve civilian needs. The emphasis was on making surgical treatment available within the "golden hour."

The Omnibus Health Care Act of 1989 called for the establishment of rules by the state health department aimed at putting in place a statewide trauma care system. "There is no system in Texas," says Dr Anderson. "There are very few in the United States. Hospitals do a valiant job to provide a safety net, but it's not sewn together well enough." What Texas has are regional congregations of resources. Because the legislature did not fund the statewide system, the regional "systems," such as they are in Texas, have relied on local tax funds, gifts, and donations, even bake sales.

The Panhandle Emergency Medical Services System, headed by Ms Ferrell, has been in operation since 1975. Initially, federal grants were used as seed money and then the system turned to the United Way. Now, local governments are levied annually at a fixed rate and they come up with the fees by a variety of methods. In East Texas, Dr Moore says, many communities have simply passed the hat in order to ensure that they can have a ready-to-go ambulance for their community.

The East Texas system enjoys the use of a helicopter to transport patients from the Level II trauma facility in Tyler to Dallas or Houston, particularly in cases involving burns or pediatric trauma. The Panhandle has no helicopter and the furthest point in the system is a 3-hour ambulance ride from Amarillo.

In both regions, as is the case throughout the state, there is no single 911 system. The Panhandle is served by two telephone systems and 911 service is not available in all counties. In contrast, Dr Anderson points to several countries, including Israel and West Germany, that have all-encompassing emergency communications systems including emergency phone systems on major highways.

The language of trauma care

Designations of facilities

Trauma care as defined by the proposed EMS/trauma system rules:

Comprehensive trauma facility — A Level I trauma facility providing comprehensive trauma facilities to manage major and severe trauma patients, provide educational opportunities in trauma-related topics for health-care professionals, and conduct trauma research.

Major trauma facility — A Level II trauma facility providing facilities similar to Level I hospitals, but without the requirements for research and some medical specialty areas.

General trauma facility — A hospital designated as Level III, providing resuscitation, stabilization, and assessment of injuries prior to transfer to a higher level facility.

Basic trauma facility — A Level IV trauma facility providing resuscitation, stabilization, and able to arrange for appropriate transfer of the patient to a higher level trauma facility.

Lead trauma facility — A trauma facility that has made additional commitment to its trauma service area. Usually offered by the highest level of trauma facility in a given service area, and includes outreach and increased educational activities. The responsibilities may be shared by trauma facilities.

Physicians gain under a statewide system

WHILE THE communications system is a patchwork, the Panhandle EMS system does have transfer protocols in place so that patient transfer from doctor to attending emergency physicians is not a hindrance or a delaying factor. That is one of the most frustrating tasks facing physi-

Emergency medicine physicians

Supply and demand

TEXAS RANKED NUMBER THREE AMONG the states in emergency center visits in 1989, the latest numbers available from the American Hospital Association, but it ranks seventh in the number of emergency medicine residency programs and available residency slots. The number of emergency center visits grew by 24.7% between 1974 and 1986 and that trend promises to continue as more patients turn to the emergency center as primary care provider.

Texas has three programs and 70 positions. Among the larger states, the state is far outranked in both the number of residency programs and slots — California has 13 programs with 349 positions, New York has nine programs and 225 positions, Pennsylvania and Illinois both have six programs with 140 and 197 positions respectively. The lack of emergency medicine residencies is an aberration in terms of overall resident numbers. Texas is third among the top four most populous states both in population and the number of residents per 100,000 population, according to the *Journal of the American Medical Association.*

"It is a great concern," says Michael P. Wainscott, MD, president of the Texas College of Emergency Physicians and an assistant professor in emergency medicine at The University of Texas Southwestern Medical School in Dallas. While there has been dramatic growth nationwide since 1981 in the number of physicians practicing the specialty, according to the American Board of Medical Specialties, Texas programs have not kept pace with the demand.

The Texas numbers also are misleading since two of the three current emergency medicine residencies are operated by the military with their graduates going into military service, plus not all graduates of civilian programs remain in Texas. Military programs include the Darnall Community Hospital Program at Fort Hood in Killeen and the Joint Military Medical Command in San Antonio. The program at Texas Tech in El Paso only graduates about six residents a year and is undergoing some revision at this time. A few additional positions will be created with the approval of the new Texas A&M program at Scott & White Hospital in Temple.

A relatively new specialty, emergency medicine is also a very popular one, and some states, for example California, have created numerous programs to meet the need. Dr Wainscott reports increasing numbers of medical students joining emergency medicine groups on campus and seeking information on the specialty. Students say they are drawn to it for three reasons, according to Dr Wainscott. They enjoy practicing acute care versus chronic care, they like the variety of procedures called for in emergency medicine, and they appreciate the schedule of an emergency physician, which allows for a balance of personal and professional time.

However, in 1989, only 1.3% of medical school gra uates in Texas chose emergency medicine as their fir choice of residency, less than the 3.1% nationwide.

Dr Donald Gordon, an emergency physician wh serves as medical director to the San Antonio EMS, sa many physicians who rotated through the emergen room a decade or more ago would see many chang there. "The emergency room has gotten a lot more s phisticated and hi-tech," Dr Gordon says. "Emergen physicians are doing more surgical procedures and a acutely aware of internal medicine problems."

The pace and pressures have increased, also, accor ing to Dr Dighton Packard of Baylor University Medic Center in Dallas. "When I was here 17 years ago I w seeing 30,000 patients a year. If I saw one gunsh wound once a week, it was news, major big-time new Now if I don't see one a day, it's unusual and I am seei 52,000 patients a year."

While interest is high among medical students wit hundreds of applicants seeking a single residency pos tion, Dr Wainscott says the lack of residencies has led t shortages, shortages that are the number one topic raise at every meeting of his peers. A recent American Colleg of Emergency Physician staffing pattern study indicate there is a need for as many as 26,320 full-time equiva lents in emergency medicine. There are approximatel 9,000 board-certified emergency physicians working fu time in emergency departments.

Some, like Dr Ron Anderson, chief of Parklan Memorial Hospital in Dallas and chairman of the boar of the Texas Department of Health, blame the lack residencies on "turf battles" within medical ranks. U Southwestern has tried three times and been "turne down flatly," Dr Anderson said. The process has bee frustrating and he blames turndowns on interspecialt politics and failure of the review committee to recogniz that one program doesn't have to look like anothe

Number of emergency room visits, residency programs, and residenc program positions, by state.

State	No. of Emergency Room Visits, 1989*	Residency Programs**	Positions** 1989-1990	Positions** 1991-1992
California	9,103,542	13	349	349
New York	6,927,505	9	225	225
Texas	4,997,102	3	84	70
Pennsylvania	4,856,661	6	140	140
Ohio	4,611,264	7	160	152
Florida	4,487,535	2	73	67
Illinois	4,068,774	6	184	197
Michigan	3,389,737	6	170	157
Massachusetts	2,898,808	2	54	55
Georgia	2,827,631	2	39	49
Total nationwide		83	2,065	2,072

**Source, American Hospital Association's Hospital Statistics, 1990-91 editio*
***Source, 1991-92 Directory of Graduate Medical Education Program (ACGME)*

ırkland has divided its emergency ·nter into four units — ob-gyn, edicine, trauma, and psychiatry — lus it operates a pre-admission iage station that diverts some pa-ents in need of routine primary ıre to a late-night clinic. That inno-ıtive approach doesn't match the pical approach.

Another factor in the battle for sidency program status, cited by ıe American College of Emergency hysicians, is the competition for windling resources, both to fund aching programs and residency ipends. Dr Wainscott says a major sue over establishing a residency rogram at Parkland has been facul-supervision. If attending coverage ın be increased, he thinks Parkland ill get a residency program in the ext 2 or 3 years.

A recent study by *US News & Vorld Report* that named the top n hospitals in the country found ıat only three have emergency resi-ency programs. "Many major aca-emic medical centers do not have mergency medicine programs," Dr Vainscott said. That is often caused y the resistance of the "old guard") new programs, says Dr Gordon.

"We're emergency medicine oor," Dr Gordon says, adding that exas is facing an emergency physi-ian shortage directly caused by the ıck of residency programs. Emer-ency physicians in Texas earn as ıuch as their counterparts in other tates, but there are simply not nough programs, so students go lsewhere, according to Dr Gordon.

Emergency medicine is the fastest rowing specialty in the nation, ac-ording to AMA numbers. Current-y, there are approximately 15,200 mergency medicine specialists in he United States. That number is rojected to increase by 50.6% over he 1988 figure of 13,800 by the ear 2000 and by 80.5% by 2010. Currently, the growth in residency rograms has come in other states.

A system *would* ensure *rural doctors* THAT THEY WERE NOT *alone* IN FACING A crisis *and that, in turn, might* encourage more physicians *to* practice *in* rural areas.

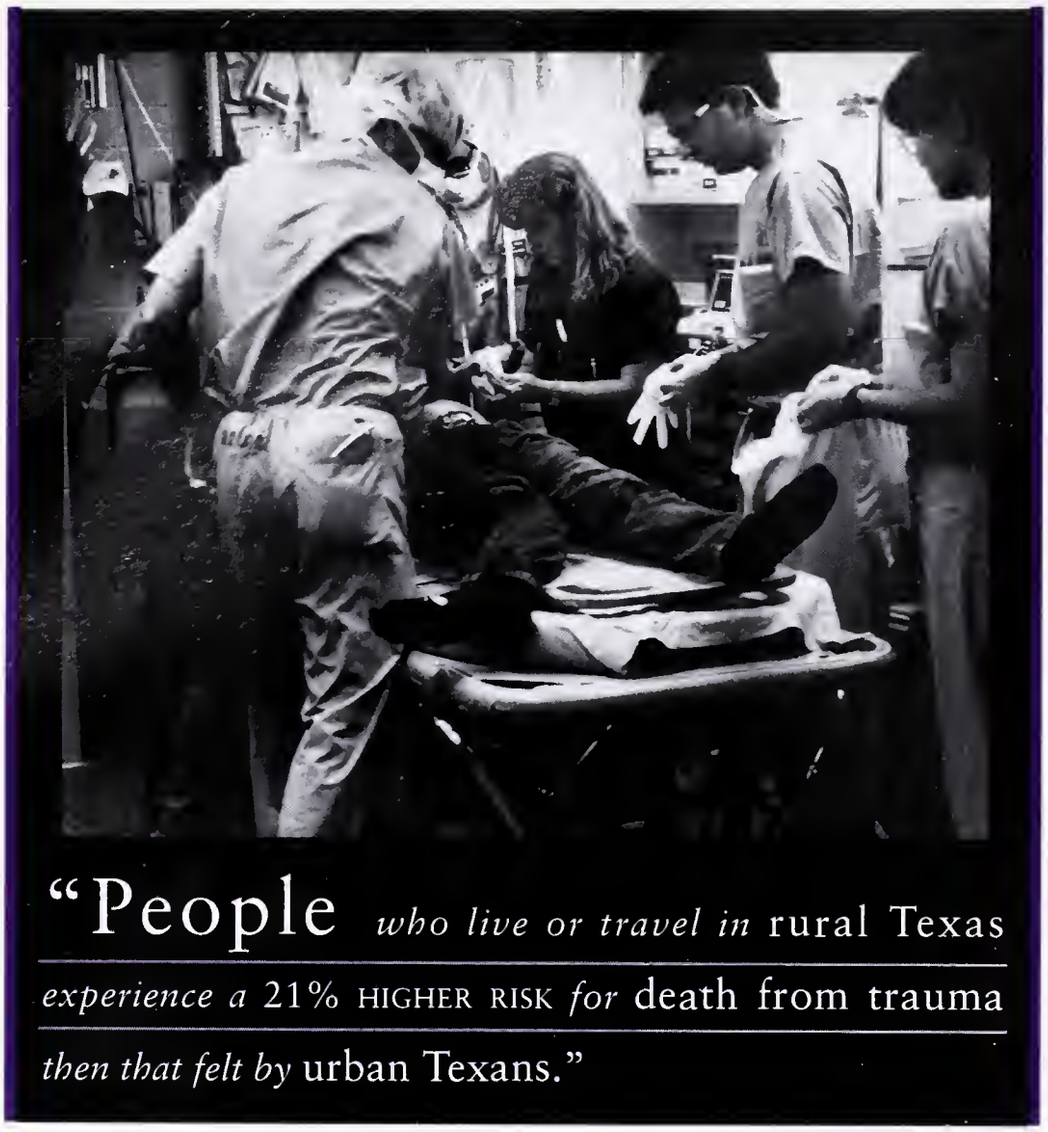
cians, particularly rural doctors, Dr Moore says.

One advantage in a statewide system, according to Dr Anderson, is that rural doctors would benefit from prearranged protocols. "They might not have a problem with what I call reverse dumping. Now when they have a problem patient, if there is an insurance opportunity they may be able to get that patient transferred. If the patient doesn't [have insurance] and they are not part of a system, then they have to negotiate that transfer. It would really expedite the writing of letters of agreement and affiliation arrangements."

A statewide system would benefit both rural doctors and hospitals, Dr Anderson says. "It would expedite patients they might want to transfer and patients they might receive back for rehabilitation. They could participate in a bidirectional mode." A system would also ensure rural doctors that they were not alone in facing a crisis and that, in turn, might encourage more physicians to practice in rural areas, Dr Anderson adds.

Ms Ferrell believes the Panhandle system does allay some fears of doctors practicing in rural areas, adding that coping with trauma care is a direct cause of burnout among rural practitioners. Dr Gordon, with the Bexar County system, sees some of those pressures among physicians in South Texas. "There are a lot of areas of Texas where you don't have a formal organization of referral . . . and every case has to be coordinated, every case is a whole story."

It is not unusual, Dr Gordon says, for a physician in Eagle Pass to face the daunting task of arranging a transfer to San Antonio, a 6-hour ambulance drive, or for a Rio Grande Valley doctor to try to coordinate with several attending physicians in Houston for a 9-hour transfer to that city. "In rural areas of Texas, resources are severely limited and options and alternatives arduously difficult to obtain," says Dr Gordon. While sophisticated paramedic teams, so-called advanced



"People *who live or travel in* rural Texas *experience a* 21% HIGHER RISK *for* death from trauma *then that felt by* urban Texans."

life support systems (ALS), can be found in many urban settings, rural areas often rely on basic life support systems (BLS). Gene Weatherall, head of the state's bureau of emergency management, says professionals refer to this as the 7-Eleven theory — there is always one around in the city, but they are hard to find in rural areas.

Delay, emergency physicians say, is an anathema in acute trauma care. The "Texas Trauma" study examined 1989 trauma death statistics and concluded that Texas rural residents had a trauma mortality rate of 56.9 per 100,000 population, while the rate among urban Texans stood at 47.1. "People who live or travel in rural Texas experience a 21% higher risk for death from trauma than that felt by urban Texans," the study found.

Advocates face tough political fight

THE STATEWIDE emergency system is being advocated by a coalition of groups, including TMA, the Center for Rural Health Initiatives, the Texas Hospital Association, the Texas Academy of Family Physicians, the American College of Emergency Physicians, the American College of Surgeons, and others. The system under consideration is outlined on page 42. Advocates have suggested a variety of methods for funding the system. Dr Gordon sums them up succinctly:

"Fund them with a nickel on every bullet, $10 on every speeding ticket, and a $5 surcharge on every bottle of booze. Do you want good care for your family or do you want cheap booze?"

In his August 1991 letter to Governor Richards, Dr Anderson proposed a user fee concept that might add a $10 vehicle registration fee or a fee for handguns and automat weapons. Another funding mech nism might be a "Med-Pay" syste that would add a small surcharge c every auto insurance policy to cov motor vehicle accident injuries.

Dr Anderson recognizes he may l taking on some of the most powerf lobby groups in Austin, but he sa this will give them a chance to wear white hat. "They will respond in se interest," he says. Powerful lobb groups have made tackling healtl care issues a difficult fight in the sta legislature. Dr Anderson says politic reality serves as one of the reasons h has suggested the statewide traum care system include some method c indemnification. "I'm tired of seein good health-care legislation killed b cause when you try to get tort refor and tie it onto the tail of the dog, yo always kill the dog. The same thing true when you go after the beer lobb . . . but alcohol brings a lot of peopl to us, it's involved in car wrecks 54% of time, and 75% to 80% of the gur shot wounds involve alcohol."

He would also like to push fo mandatory trigger guards with ever handgun sale and confiscation of as sets in drug cases. Florida is usin $5 million from the sale of confisca ed assets to fund a new trauma cer ter. Some of those funds should als be targeted for drug interdictio strategies and efforts to comba gang violence, says Dr Andersor "We don't want to create just a bet ter trauma mousetrap. We also wan to decrease the number of peopl who get injured. We have been suc cessful with blunt trauma legislatio like seat belt restraints, child safet restraints, helmet laws, and toughe DWI laws. But we haven't focuse our attention on penetrating injury."

All physicians can help

DR PRENTICE, chairman of th TMA trauma and EM committee, and other pro ponents of the proposed sys tem would like to see Texa physicians become mor aware of the extent of the traum care crisis and its impact on th health-care system. He points ou

hat injury is a major public health is-ue with a socioeconomic impact ex-eeding cardiovascular disease and ancer combined. "Physicians must onstantly work to educate their pa-ents that they are at risk for serious njury in their homes, at work, in heir cars, and while at play," he says.

In addition to pressing for legisla-ive action, Dr Gordon suggests hysicians could assist in simple vays. "Community physicians need o learn how to interact with the MS," he says, plus they need to give heir patients some understanding of ow the system works and discour-ge them from abusing the system — Get grandma when she has a sore hroat to call a taxi for $20, rather han an ambulance for $120."

All physicians have a stake in olving the trauma care crisis, says Dr Moore. "It's hard to name a spe-ialty that we don't keep in bed at ight." One specialty group that is eeling the stress is the state's trauma eurosurgeons. At Baylor, according o emergency medical director Dr Packard, neurosurgeons have been n call two and three times a week. It's hard to operate all night and hen operate all day."

There have been cases in Texas of rivate hospitals "raiding" hospitals vith trauma centers and enticing verworked neurosurgeons away vith promises that they won't have to ake call in the specialty, according to Dr Anderson. "That's the kind of hing communities ought to raise cain bout," he says. "Maybe the time has come for us to say if you work here, you take call in your specialty."

In attempting to bring home his message of a Dallas trauma system in crisis, Dr Anderson says he has turned to the trustees of various Dallas hospi-tals and local CEOs. An informal ar-rangement is in place in Dallas County, dubbed by the media as a "Band-Aid plan." Last summer, several private hospitals pledged to back up Methodist and Baylor University medical centers on a rotating basis. Parkland remained the city's primary trauma center.

Unfortunately, in the urban areas, the trauma care crisis is often per-ceived as being a problem disassociat-ed from the middle class mainstream.

"We don't want *to create just a* better mousetrap. *We also want to* DECREASE THE NUMBER *of* people who get *injured*."

"You always think it's these people or those people, not me," says Dr Anderson. "On the other hand, if you are a car wreck victim and you are in an emergency room trashed out with gunshots, then obviously you would have some interest in this right away."

Heightening public awareness is at the heart of the problem facing those advocating a statewide trauma system. "There's a consensus that without resources, both funding for acute care as well as injury prevention and control programs, it's not going to happen," says Dr Prentice. In addition, supporters of the proposed system say there must be an indemnification provision for physicians who provide emergency care. Mandated care must be matched with indemnification, Dr Moore says.

There were expectations last summer that the trauma care crisis would be addressed in a special session, but that appears highly unlikely now. Some advocates of action, including TMA and Dr Anderson, are concerned that the trauma care crisis will get buried in the overall issue of health care.

"The state just has to understand this is like a utility. Do you want it there for you, or not? It's like an insurance policy for all citizens," Dr Anderson says. "In talking to the governor, I don't think there is any resistance to addressing this issue, except that she sees the much broader issue (health-care policy) as taking precedent . . . The truth is we have studied it to death and we don't need to study it anymore . . . It's like looking at a hot horseshoe. How long do you hold onto it? We've held on to it long enough and my concern is that if we don't do something before next summer, the system in Dallas is going to fall apart . . .

"I think the largest population areas are on a precipice here. The rural people know about this. It's time to act before the thing falls apart. The proper political leadership is going to take the position that we do it before it falls apart. I think if we wait until 1993, it will be like bringing a phoenix out of the ashes." ★

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Science and Education

TMA Library receives NLM grant for East Texas outreach program

THE DISTANCE BETWEEN physicians in deep East Texas and vital medical information just got a lot shorter.

The Texas Medical Association Library has received a $25,000 grant from the National Library of Medicine (NLM) to provide outreach services to health professionals in East Texas through a hospital-based information network.

The grant program will provide access to the resources of the TMA library via the Rural Health Information Services Network to physicians through hospitals in Red River, Van Zandt, Panola, Shelby, and Polk counties. The counties constitute a medically underserved area as defined by the Texas Department of Health.

"Our primary goal has always been to meet the information needs of the practicing physician, with a special interest in those choosing to locate in the rural areas of the state," said Susan Brock, TMA library director. "This outreach program will allow TMA to extend its reach even further into the hospitals where physicians spend much of their time."

Funding for the project began in October 1991 and will continue through March 1993. One hospital in each county will receive a work station that will include a computer, modem, printer, fax machine, and a Grateful Med/Loansome Doc software package. Each hospital also will receive an on-site training session for use of the equipment and software.

Services by TMA will include photocopies of selected journal articles, interlibrary loan, and document delivery via fax or mail.

During the 18-month period, the projects will introduce Grateful Med to a wide range of physicians and other health-care professionals, including dentists, nurses, medical students, health administrators, and other allied health professionals. The NLM/TMA program is designed to serve health professionals in nonmetropolitan areas, health professionals in underserved inner city areas, minority health professionals, and health professionals serving primarily minority populations.

The TMA library is one of 15 medical libraries around the country to receive the NLM grant and one of three in Texas. In addition to TMA, the Moody Medical Library at The University of Texas Medical Branch at Galveston (UTMB) and Library of Health Sciences at Texas Tech University Health Sciences Center in Lubbock each received a $25,000 grant.

The Moody Medical Library at UTMB will provide outreach services to rural physicians and other health-care workers in several underserved Southeast Texas counties, while Texas Tech will introduce Grateful Med to physicians and health-care practitioners in the Hispanic urban areas of El Paso.

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

'Closing in on Cancer' exhibit on display until February 15

"CLOSING IN ON CANCER," a traveling exhibition from the National Cancer Institute, will remain on display throug February 15 in the first floor lobb of TMA headquarters as part of th ongoing History of Medicine preser tation.

The walk-through display chron cles cancer from the first mentions c the disease almost 5,000 years ag to research in the 1980s. Viewer may follow a time line that inter weaves the histories of science medicine, and cancer research fror ancient Egypt to the present. The ex hibit, which is comprised of 21 dra matically lit panels and weighs mor than 10,000 pounds, tells the stor in hundreds of colorful illustration and photographs, short, clearly writ ten narratives, and three short vide presentations.

The exhibit is on display 8:15 ar to 5:15 pm Monday through Friday and from 9 am to 1 pm on Satur days in the lobby of TMA headquar ters at 401 W 15th St in downtow Austin. The exhibit is closed o some holidays. For further informa tion, contact TMA library directo Susan Brock at (800) 880-1300 o (512) 370-1540.

Texas medical schools get share of $60 million in research grants

BASIC SCIENTIFIC RESEARCH in Texas has received a $6 million shot in the arm, as th Texas Higher Education Coordinat ing Board has awarded 421 researc grants to 34 Texas colleges, universi ties, and research institutions, in cluding more than $12 million t Texas medical schools.

The board approved the award last October after a 4-month revie process in which more than 3,00

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

nformation for this column comes from a variety of sources, including aca-'emic institutions, state and federal agencies, and private institutions. To ubmit items of interest, write Texas Medicine, *Science and Education Edi-or, 401 W 15th St, Austin, TX 78701.*

Test detects AIDS virus in early stages

he University of Texas Medical Branch at Galveston — Researchers at UTMB have discovered a method to detect the AIDS infection in its cru-ial early stages when the virus can be transmitted but still evades accepted ests. The test cuts the 3-month to 3-year time before the presence of the irus can be detected to as little as 4 to 6 weeks. It pinpoints specific anti-odies that are formed against human immunodeficiency virus (HIV) earlier han the currently accepted test. The immune system makes these early anti-odies in response to HIV proteins that are synthesized and on display on he membranes of infected cells as the virus reproduces. Miles W. Cloyd, hD, professor of microbiology and leader of the research team, said he ex-ects to have the new test available for use in about 6 months.

Blood tests help determine best dose of antidepressants

he University of Texas Southwestern Medical Center at Dallas — Researchers have found that blood tests that can now be performed at nost major hospitals can make a major difference in the successful treatment of patients on antidepressant medications. Paul J. Orsulak, MD, professor of sychiatry at Southwestern, has been studying a group of tests that can pre-isely measure the levels of drugs in the blood. Dr Orsulak said about half the atients taking antidepressants are given dosages that are too high or too low or their conditions. While recommended dosages of antidepressant drugs are et by manufacturers based on average requirements, Orsulak said, the chem-stry of depression is very complicated and a blood test is needed to determine he exact dosage for a particular patient. He adds that blood tests can be used o avoid the trial and error method often used to find an appropriate dosage of antidepressant medication.

Sexually transmitted diseases target of major new grant

he University of Texas Health Science Center at San Antonio — The Sex-ually Transmitted Diseases Research Center at UTHSC-SA has received a 4-year, $6.1 million grant from the National Institute of Allergy and Infec-tious Diseases (NIAID) to fund research into the development of vaccines for some STDs and to study the relationship between AIDS and other STDs. The new center — one of five in the US funded by the NIAID — will focus on behavioral studies, outreach efforts, and patient care. According to Joel Baseman, PhD, director of the center, outreach efforts will extend to the Rio Grande Valley and west along the US-Mexico border. Other universities in-volved in the study are University of Washington, Seattle; University of Cali-fornia, San Francisco; Indiana University School of Medicine, Indianapolis; and University of North Carolina, Chapel Hill.

AIDS Research Center established to consolidate programs

aylor College of Medicine, Houston — An AIDS Research Center has been established at Baylor to consolidate its nearly $10 million in AIDS research under a central umbrella organization. William T. Shearer, MD, one of Baylor's leading AIDS researchers, has been named director of the center. More than $3 million at Baylor is directed towards studies exploring diagno-sis and treatment methods for young AIDS patients. Other key areas of AIDS-related research at Baylor include studies of gene therapy, studies at the molecular level of how the virus behaves, and potential treatments for tuberculosis and other AIDS-related complications.

submissions were examined by 15 sci-entific and industrial review panels.

The grants were awarded in two main categories: $20 million in 12 fields for the Advanced Technology Program and $40 million in 12 fields for the Advanced Research Program.

"Since the legislature created the Advanced Technology Program and the Advanced Research Program in 1987, we have been building the kind of research environment that attracts the best scientists and en-courages innovative industry," said Harry Reasoner, JD, chairman of the coordinating board.

Kenneth H. Ashworth, PhD, Texas Commissioner of Higher Edu-cation, said the funds awarded for medical research were particularly important.

"Under the Advanced Research Program, 169 research teams will conduct basic research to help ad-dress society's needs," said Dr Ash-worth. "For example, one award to UT-Southwestern Medical Center will fund a study of chromosomal translocation in relatively rare cases of lymphocytic leukemia in children. Through this study, the research team hopes to discover new insight into the fundamental processes that cause this disease."

Of the $12.2 million awarded to medical schools, Baylor College of Medicine in Houston received the largest amount, $3,179,603 for 16 projects. In addition, The University of Texas Southwestern Medical Center in Dallas was awarded $2,939,459 for 19 projects; the UT System M.D. Anderson Cancer Cen-ter in Houston, $2,121,562 for 14 projects; UT Health Science Center in San Antonio, $1,138,814 for 7 pro-jects; UT Health Science Center in Houston, $1,137,892 for 9 projects; UT Medical Branch at Galveston,

$633,669 for 5 projects; and the Texas Tech Health Sciences Center in Lubbock, $496,513 for 4 projects.

The board also allocated $561,097 for 4 projects to the Texas College of Osteopathic Medicine in Fort Worth.

The coordinating board program is the nation's largest competitive, state-supported grant research program. The grant awards were based on the recommendations of independent, peer review panels and the board's Advisory Committee on Research Programs.

TMA distributes "Milestones in Medicine" poster

JOHN W. BURNSIDE, MD, of Dallas, chairman of TMA's Council o Scientific Affairs, and Mary Rust, TMA coordinator of scientific affairs, d play a poster on "Milestones in Medicine" that was recently presented more than 6,000 science teachers in Texas as a classroom instructional ai The poster was designed by The University of Texas Health Science Center San Antonio for the Texas Society for Biomedical Research. The Council o Scientific Affairs reprinted and distributed the poster at the Science Teache Association of Texas conference at College Station last October.

COMMENTARY

Ethical concerns surround CME sponsorship by the pharmaceutical industry

Lary R. Kupor, MD
Department of Internal Medicine, St Joseph Hospital

Scott A. Kupor
Student, Department of Public Policy, Stanford University

SEVERAL PREMISES UNDERLIE the formation of conflict of interest policies, but the most basic assumption is that physicians, under monetary pressure from pharmaceutical companies, may compromise their ethical responsibilities to their patients and the medical community. While it is generally accepted that medical professionals do not bias information knowingly, the possibility exists for physicians to be unknowingly swayed by marketing techniques (1). Given this presumption, what are the consequences of a physician-pharmaceutical company relationship?

In the worst case scenario, the patient of a physician influenced by pharmacological advertising may suffer medical complications from an improper drug or may pay a higher price for a drug that is no more effective than its generic equivalent. Physicians engaged in research for a drug company may also compromise their methodology in the interest of maintaining a favorable relationship with the organization.

Applying a consequentialist ethical analysis, one is obliged to weigh the resulting harm and well-being from the policy. While the potential for physicians to be misled exists, all commercially advertised drugs are FDA approved, thus mitigating an adverse reaction in the patient. Similarly, responsible physicians should monitor the patient's reaction to the drug and make any necessary changes. Although the prospect of a patient's suffering harm at the hands of his physician is unsettling, one should also consider the role of the legal system in upholding reasonable standards of care. An irresponsib physician who has been persuaded t use a less effective medication an who subsequently fails to monitor h patient's reaction to the drug breaching this duty and subject to l ability. Additionally, given the impo tance of colleague consultation (2), physician who has been prescribin an effective drug may seek advic from his fellow practitioners. Th communication is likely to reduce th commercial influence of a drug an to reflect collegial experiences wit other successful forms of medication

Assuming then that the likel hood of patient harm is kept i check by the physician's legal re sponsibilities to his patient and co legial consultation, one must turn t the issue of higher costs. Is it possi ble that a patient will pay more fo an equally effective drug because o a physician's monetary holdings in pharmaceutical company? Here too, the medical market has built-i mechanisms that lessen the likeli

ood of such an event. Since the full dvent of prospective payment in 987, the reimbursements provided ospitals have lagged behind actual osts, forcing them to incur losses or treating Medicare patients (3). In he wake of prospective payment, hysicians have been encouraged to ower the costs of treating patients, ncluding the substitution of generic nedication when possible. As insurnce companies continue to tighten heir reimbursements, medical pracitioners will become even more likey to seek viable methods of cost ontainment. Peer review organizaions, among other things, monitor hysician prescription behaviors and nay recommend the use of the least xpensive medication that can successfully treat a patient's disorder.

Because the opportunity costs asociated with attending continuing nedical education (CME) conferences are cited by physicians as a main deerrent to greater CME participation 4), the coverage of travel expenses by pharmaceutical companies presents a conflict between ethical concerns and practical considerations. If the monetary costs of travel and lodgng are eliminated, physicians may be enticed into closing their practices for a few days to attend a conference. Is it worthwhile for physicians to receive some sort of continuing education despite the appearance of impropriety? With or without the sponsorship of CME conferences, drug companies will continue to market their products (1), adding to the billions of dollars spent annually. Given the privacy surrounding the visitation of a sales representative with a physician, the prospect of misconduct is more likely there than in a large conference setting.

Conclusion

Given the legal and economic factors affecting physicians' decisions and the trade-off between attendance at conferences and subsidizing expenses, it is our opinion that ethical concerns surrounding the potential for conflict of interest between the pharmaceutical industry and physicians are not as substantial as some have suggested. Reducing the influence of the drug industry will not solve the underlying problem that CME proponents have failed to address: the apparent lack of interest among physicians in continuing education. Efforts should be directed at understanding the reasons physicians resist CME and thus turn to commercial advertising for medical information. Physicians must be convinced of the importance of CME in a rapidly changing technological field, and educational opportunities must accommodate their time constraints.

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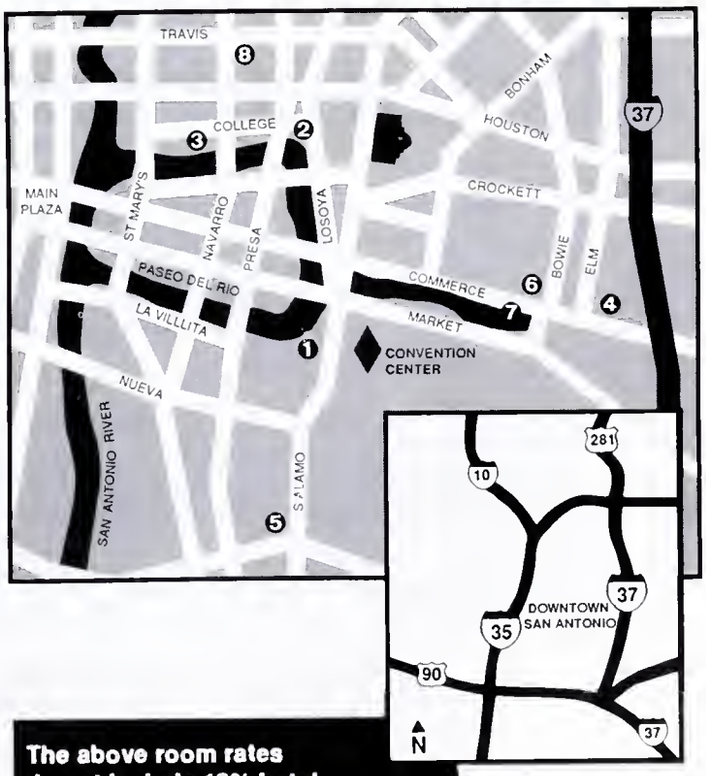

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Medical Economics

Physicians say some hospital corporations abuse Rural Health Clinic Program

HEALTH CARE GOT A MUCH-needed boost in 1989 when the Texas legislature passed the Health Care Rescue Act (House Bill 18), making it feasible for rural health clinics (RHCs) to make a go of it in Texas. But an apparent loophole in the federal regulations governing such clinics may make the cure worse than the disease in some Texas communities.

The problem, say some rural physicians, is health-care corporations setting up rural health clinics, staffed by only physician assistants (PAs) or nurse practitioners (NPs), in direct competition with established physicians in small towns, often bypassing several other small towns without doctors.

While such an arrangement appears to be well within federal Health Care Financing Administration (HCFA) regulations, many rural physicians and those who sponsored the legislation say it goes far beyond the intent of the law. And both state and federal regulators say their hands are tied in the matter.

Meanwhile, such clinics have cost Texas the services of at least one rural physician, and have pushed others to consider pulling out if a remedy cannot be found.

Steve Townsend, MD, an internist formerly practicing in Lockhart, pulled up stakes last year and joined a rural practice in Cottage Grove, Ore, a city of 8,000 about 20 miles from Eugene.

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

Dr Townsend said his primary reason for leaving Lockhart was the lack of quality health care available after Seaton Corporation of California leased Community Hospital of Lockhart from the city, shut down the emergency room, and began operating an RHC in its place.

"It was a quality of care issue, mainly," Dr Townsend said recently from his practice in Oregon. "You know, we loved it there in Lockhart. We didn't want to move."

Patients seen on an emergency basis at Community Hospital in Lockhart first see a PA, and if necessary, a physician is on 30-minute call. The alternative is a 30-minute ambulance ride to Austin.

There were other issues that came into play. Dr Townsend said while he had made a commitment to practice medicine in rural Texas, there were limits to the amount of hardship he and his family could take.

"It's a sacrifice to work in a smaller town. You get reimbursed less by Medicare, you have a more demanding life-style, not like with a group of 20 doctors where you are on call every 20th night. They were just trying to dump too much of the emergency room coverage on us to the point that we couldn't have a life with our families. It was just flat unfair." he said.

Dr Townsend resigned from the hospital staff about a year before he moved to Oregon. He said it doesn't make sense to him that an RHC operates in a town where there are already practicing physicians.

"They are in direct competition with several family practice and ot er physicians in the area," he sai "They've driven one doctor out town. So how does that help tl community?"

> "I DO NOT WANT TO PRACTICE IN COMPETITION WITH SOMEBODY WHO GETS COMPENSATED THREE TIMES WHAT I DO AND DOESN'T EVEN HAVE A DOCTOR'S LICENSE."

In Mathis, a South Texas town about 5,000, Riverside Hospit from nearby Corpus Christi has s up an RHC four blocks down tl street from Ronald Mu son, MD.

Dr Munson said th RHC's ability to colle considerably higher Med care fees (using only a PA than he can for the sam service is reason enoug for him to be angry abou the situation. But he sai there is another aspect c the situation that disturb him even more.

"Rural physicians ar being put in a positio where we have what I cor sider second-class healt care competing with a first class provider," he saic "It allows them to pas through a large amount c their hospital overhead ex pense into the clinics an get maximum reimburse ment from Medicaid an Medicare, which will b very expensive to the system."

Dr Munson said the corporatio operating the clinic, Epic Healt Care of Dallas, owners of Riversid Hospital, is doing so in violation o the spirit of the law that created th Rural Health Clinic Program.

"They put their very first rura health clinic out of Riverside Hospi tal in Mathis, in competition witl three physicians and three clinics i town. It is not in a federal manpow er shortage area," he said. "It doe qualify as a medically underserve

RURAL HEALTH CLINIC PROGRAM FILLS VITAL NEED IN TEXAS

For the majority of Texas communities where rural health clinics (RHCs) have een established, the program has eant increased access to health are where there had previously een little or none.

According to the Texas Depart- ent of Health, as of late Novem- er 1991, there were 31 RHCs ap- roved to operate in Texas, while 6 more applications were awaiting pproval by the Health Care Fi- ancing Administration.

The need for such clinics is great, ccording to information rovided by the Center for ural Health Initiatives in ustin. Of Texas' 254 ounties, 205 are rural. Of e 16.9 million people in e state, 20% of the popu- ation is nonmetropolitan nd lives on 80% of the and. According to the cen- er, the rural population of exas is larger than the to- al combined populations f Alaska, Delaware, Nevada, Vermont, and Wyoming.

Antonio Falcone, MD, f Rio Grande City, was ne of the first Texas hysicians to convert his practice. According to Dr Falcone, he and his artners were almost forced to shut lown their practice because of Medicaid cuts.

"We were about to close our loors when we heard about rural ealth clinics. I hadn't taken a check ome in 3 months," he said. "Now we are financially stable. Every physi- cian in a rural, medically underserved area should look into this program."

The concept of RHCs began in 1977 when Congress passed the Ru- ral Health Clinic Services Act, which was originally aimed at rural commu- nities in Appalachia that had difficul- ty recruiting and retaining physicians.

Little happened in Texas until 1989, when the Texas legislature passed the Texas Health Care Rescue Act in response to a funding crisis that saw many rural hospitals in Texas close their doors. The bill gave physician assistants and nurse practitioners limited prescription authority.

Since then, the number of clinics has grown rapidly, and state health officials expect that trend to continue as more rural physicians and hospitals discover that they can extend their reach in a cost-efficient way into previously underserved rural communities.

"Every physician in a rural medically underserved area should look into this program."

There are two types of RHCs: independent clinics, such as those operated by a physician; and provider-based clinics, which are an integral part of a hospital, nursing home, or home health agency.

The chief attraction of creating an RHC, or converting an existing practice to one, is the ability, once certified, to receive Medicare and Medicaid reimbursements based on actual cost, rather than on the traditional fee-for-service basis. The clinic may be staffed by a physician, nurse practitioner, physician assistant, and/or a certified nurse midwife. In those clinics where a full-time physician is not present, a physician must provide supervision and guidance of the treatment and care given, and the physician must review the services provided. The clinic must be located in a medically underserved area or a health professional shortage area for primary care physicians.

RHCs are certified by the Texas Department of Health and approved by HCFA.

For more information about RHCs, contact Karen Batory, TMA department of health care delivery, at (800) 880-1300 or (512) 370-1401.

census tract, one of 10 in San Patricio County. That means they had to step over six of the medically underserved census tracts to put one here in competition with established physicians.

"I want to leave," he said. "I do not want to practice in competition with somebody who gets compensated three times what I do and doesn't even have a doctor's license. Their obvious motivation has to be financial. They want access to this area to get direct referrals to their hospital."

At the end of November, Dr Munson and other Mathis physicians were considering converting their practices to rural health clinics.

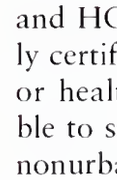
Officials from both hospital corporations said their clinics are not only in compliance with all regulations governing the clinics, but are filling a need in the communities where they are located.

"It's a normal extension of our services," said John Barone, administrator of Community Hospital in Lockhart, which also operates RHCs in nearby Luling and Bastrop. "For example, in Bastrop, there are about one and one-half or two doctors in the town, and their hospital closed 3 years ago. We see a lot of patients from there and from Luling."

Al O'Connell, of Epic Health Care in Dallas, owners of the RHCs in Mathis, Taft, San Diego, and Port Aransas, said his company has a formula for choosing sites for its clinics.

"In addition to whatever qualifies under the federal guidelines, we do a physician-need analysis in terms of the available population and the current level of physicians," he said. "So beyond the guidelines, we look at the prudence of putting in a clinic from an economic standpoint."

According to officials of the



Texas Department of Health (TDH) and HCFA, the agencies who jointly certify RHCs in Texas, a hospital or health-care corporation is eligible to set up a clinic anywhere in a nonurbanized area of the state that has been designated a "medically underserved area," a "medically underserved population," or a "health manpower shortage area."

"Our guidelines are not clear," said Maurice Shaw, director of health facility licensure and certification at TDH. "They may be setting up in an area where there are plenty of doctors, but if they meet those other guidelines and definitions (as specified by the federal government), then we have no choice but to approve them. The criteria are not clearly enough defined that we can say, 'Yes, they can only be located in rural areas where there is no physician.'"

He said RHCs locating in the same community with established physicians are a concern to state regulators, but the vagueness of regulations issued by HCFA make it difficult to know what to do.

"We've asked for clarification on these things, but getting rules out of the feds is worse than pulling hen's teeth. There are many inconsistencies in these rules," Mr Shaw said.

But Becky Peal-Sconce, a Medicare policy specialist with HCFA, said the federal regulations regarding where an RHC may be placed are very specific.

"Once you are eligible as an area or have an underserved population, that's all that's required. You could have 500 rural health clinics in that one area," she said. "I suppose after you reach a certain saturation point, if the area loses its designation, we would no longer certify any additional clinics."

She added that the federal government depends on data generated by state health departments to determine what is designated as a medically underserved area.

> "WE NEVER ENVISIONED THAT LARGE HOSPITAL CORPORATIONS WOULD USE THE PROGRAM TO COMPETE AGAINST LOCAI PROVIDERS."

Two of the key people involved in the creation of the Texas Omnibus Health Care Rescue Act in 1989 say the trend of hospitals and corporations putting clinics in direct competition with established physicians and clinics flies directly in the face of the intent of the legislation.

Mike McKinney, MD, a former state representative from Centerville, was a sponsor of HB 18 in the 1989 legislature. Dr McKinney said PA-staffed clinics competing with established physicians was far from what he intended the bill to accomplish.

"What we intended was to expand services and encourage the providers who were not taking Medicaid cases to take them because of the higher reimbursement," Dr McKinney said. "We also wanted to make it possible for existing providers to expand into either other cities or areas that it had not been cost-efficient for them to serve. We never envisioned that large hospital corporations would use the program to compete against local providers.

"If the hospital is short-sighted enough to do that in an area whe there's already a sufficient number physicians, then they will blo themselves out of the water," sa Dr McKinney. "Short term, it will a strategy to make some extra mo ey. Long term, if it has the effect driving doctors out of the area, th they've executed themselves."

TMA's director of public affai Kim Ross, said it isn't surprisi that problems are arising with t program.

"When we were doing this, v anticipated there might be son abuses of the statute, but we felt the time that the benefits outweigh the potential abuses," said Mr Ros "We decided that as they occur would identify them, and if they vi lated the law, we would be able shut them down. If they were able manipulate a loophole, we'd go ba and tighten down that loophol That's why we have a legislature."

TMA's House of Delegates h begun looking into the problem. resolution from the Bee-Live Oa McMullen County Medical Societ calling attention to the abuse RHCs by hospital corporations, w approved and referred to the Cou cils on Legislation and Health Facil ties for study and report at the TM Annual Session in May. The resol tion also was scheduled to be take by the Texas delegation to the AM House of Delegates for presentatio to that body at its interim meeting December.

TMA PRODUCES GUIDE TO NEW CPT CODING SYSTEM

As of January 1, drastic changes in the Current Procedural Terminology (CPT) coding radically affect the way physicians and their staff members handle billing. TMA has developed a publication entitled *The Coding Tree: Using the New Evaluation and Management Codes* that translates the process of using the new codes into a series of flowcharts. The book, which provides a quick reference and training guide to the new system, is offered to TMA members for $49, including tax and shipping. The nonmember price is $98, including tax and shipping. To order your copy, send a check to Medicare Coding Tree, Texas Medical Association, 401 W 5th Street, Austin, TX 78701.

COUNTDOWN TO RBRVS:

Some winners, some losers in final Medicare payment fee schedule

The countdown is over. Medicare has launched its controversial new physician payment system.

Following months of intense negotiations between organized medicine, including physicians of the Texas Medical Association, and the Federal Health Care Financing Administration (HCFA), final regulations for the resource based relative value scale (RBRVS) physician payment system were released November 15, for implementation January 1.

And while physicians saw some improvements as a result of their efforts to make the new system more fair and equitable, in Texas, physician leaders say much work remains to be done.

"Overall, because of the GPCI [geographic practice cost index], Texas was one of the bigger losers," said Louis Goodman, PhD, TMA director of medical economics. "Texas and Florida — those states that have an adverse GPCI and have sizeable Medicare populations — got hurt."

Dr Goodman said the battle to make RBRVS workable is far from over.

"One of our major initiatives in 1992, once we get the data, will be to continue our pursuit of either making the GPCI objective and reliable, or repealing it," he said.

He said that Texas physicians and TMA have already had an impact on the process.

"As a direct result of our efforts, we've had some changes already worked into the legislation, like requiring HCFA to make updates at least every 3 years, and to have a major study conducted on its validity, due out early next year," he said. TMA's efforts also increased payments in most of the Texas metropolitan areas after the association identified an error in the methodology used for the GPCI. A correction for the error was written into legislation led by Sen Lloyd Bentsen (D-Tex).

The RBRVS payment system is based on a relative value scale in which a physician's service is assigned a value reflecting the relative resources (time, intensity, risk) involved with producing that service. Values are also assigned to each service for practice expenses (billing, rent, office overhead, etc) and for medical malpractice insurance expenses. Each of those figures is then adjusted by a geographic index designed to account for varying costs of operating a medical practice, and finally, the sum of the geographic adjusted relative values for a service is multiplied by a national dollar conversion factor to yield a fee schedule payment amount.

The changes in the payment system will phase in during a 4-year period, to be fully implemented by 1996.

The final fee schedule restores 95% of what HCFA had taken away in its proposed regulations published in June. The original conversion factor calculated by HCFA (26.82) was 16% less than the "budget neutral" fee schedule agreed to by physicians and Congress in 1989. As a result, HCFA received 95,000 comments regarding the cut and adjusted the 1992 conversion factor to 31.001.

What had been a 10% behavioral offset in the proposed rules has been changed to a 6.5% "baseline adjustment" to account for projected volume changes.

By making the change, HCFA is acknowledging that volume increases are the result of many factors, including patient demand, and that no judgment can be made that such increases represent unnecessary care.

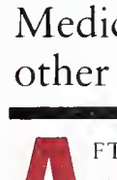
Other highlights of the final rules include:

Relative value units (RVUs) — About 1,000 of the original 4,500 relative value units were revised, based on comments received and in consultation with the medical directors of HCFA's carriers.

Global surgery — The preoperative period included in the global fee for major surgery has been decreased to 1 day in the final rules from 30 days in the proposed regulations. For minor procedures, the postoperative period has been decreased from 30 days in the proposed rule to 10 days for some procedures and eliminated for endoscopic procedures (except where an incision is required) and many other minor procedures.

Drug payments — The payment rule for drugs has been changed from 85% of the average wholesale price in the proposed rule to the lower of estimated acquisition cost or the average wholesale price.

Anesthesia services — Payments for anesthesia services based on average base and time units in the proposed rule have been retained, pending further review.



Delegates consider Medicaid fee schedule, other economic issues

AFTER MORE THAN A YEAR'S study by the Texas Medical Association, a proposed Medicaid fee schedule for Texas, modeled after the Medicare relative value scale, was approved by the TMA House of Delegates at its meeting November 15–16 in Austin.

The delegates also put their support behind maintaining a pluralistic health-care system and addressed a host of other socioeconomic issues.

The House approved several recommendations regarding the Texas Medicaid fee schedule, which has been under consideration as a way to increase physician reimbursement fees and, thus, physician participation in the Medicaid program. The House action included:

- supporting a Medicaid RBRVS fee schedule tailored to fit the specific needs of Texas physicians serving Medicaid patients, without geographic practice cost indexes (GPCIs);
- requesting that the Texas Department of Human Services (TDHS) establish an "RBRVS Modeling Group" to evaluate individual relative value units and establish the Medicaid Physician Payment Advisory Committee as a permanent standing committee;
- rapid implementation of primary care services under an RBRVS and a 4-year transition for other services; and
- a Medicaid RBRVS conversion factor at least equal to the Medicare conversion factor.

Delegates also responded to concerns that the fee schedule approach may be adopted by many or all insurance carriers by approving a strongly worded resolution to keep the fee schedule as a payment method "designed specifically to deal with the needs of the elderly and the indigent," not as the basis of a payment methodology for commercial insurance carriers.

Although Medicaid's proposed adoption of a fee schedule has drawn criticism from some physician specialty groups, Medicaid and TMA leaders have stressed their commitment to tailoring a system to the needs of Texas physicians.

"We want a system under which the cure is not worse than the disease," said Louis Goodman, PhD, TMA director of medical economics. "Unlike the one-size-fits-all approach of the Medicare fee schedule, we have an opportunity to design this system to *solve* problems, not create them."

The proposed fee schedule approach was expected to be considered by the Texas Board of Human Services late last year. If approved, the new payment system could begin as early as this April.

In other business regarding the report of the Reference Committee on Socioeconomics, the delegates:

- approved an amended version of a resolution by the Harris County Medical Society to establish a policy providing that exclusive contracts should never be used to circumvent medical staff bylaws, and that medical staff should be subject to medical peer review, due process, and recredentialing identical to other staff;
- approved a recommendation to develop and support a legislative amendment to the Texas Human Resources Code to require Me caid to utilize the Peer Revie Organization for Medicaid qua ty assurance and utilization r view; and
- approved a resolution by the Paso County Medical Socie urging the Texas Congression delegation to oppose the incl sion of disproportionate admini trative fines in new legislatio The resolution cited a $10,0 per day administrative penalty r cently imposed by HCFA on questionnaire mailed to phys cians with office laboratories.

The delegates also:

- approved a report of the Con mittee on Aging and Long-Ter Health Care proposing a poli on nursing facilities emphasizir appropriate utilization of phys cians with an interest and know edge of geriatric and chronic ca medicine as medical directors nursing homes;
- referred to the Council on Legisl tion a recommendation to see legislation providing that phys cians treating patients covered b Medicaid be protected from liabi ity to the same extent as gover ment employed physicians; and
- approved and referred to th Councils on Legislation an Health Facilities a resolution b the Bee-Live Oak-McMulle County Medical Society to see legislation and other remedies t prevent abuse of the Rura Health Clinic Program by hosp tal corporations. (See "Physician say some hospital corporation abuse Rural Health Clinic Pro gram," p 60.)

C/BS answers uestions about ParPlan, lueChoice

ATE LAST YEAR, BLUE CROSS and Blue Shield of Texas announced two new programs, arPlan and BlueChoice, to Texas hysicians. (See *Texas Medicine*, ovember 1991, p 31.)

ParPlan, which went into effect anuary 1, is a new contracting echanism which, though not a anaged care product, directly reimburses physicians at the "reasonble charge" level.

BlueChoice, to be introduced in exas in April 1992, is a managed are product using a point-of-service elivery system. Subscribers will ave a choice of providers, but typially will receive maximum benefits r medical care and hospitalization hen services are preauthorized by e primary care provider and perrmed by health-care professionals the network.

At the time of the announcement, any TMA members raised questions bout the plans. The plans were reiewed by the TMA Hospital Medical taff Section and the TMA Council n Health Facilities and several oints about the programs were disussed with Blue Cross/Blue Shield.

David S. Sowell III, MD, FACP, ssociate medical director for Blue Cross, gave the following answers to elected questions:

ON PARPLAN

Q: How are fees determined? Will there e geographic differentials?

A: Fees have been determined based n historic charging patterns of hysicians in the same or similar pecialties. There are geographic differentials. The state of Texas is divided into five areas.

Q: How often will the fee schedule be updated?

A: The schedule of allowances will be updated annually.

Q: How will non-ParPlan physicians be reimbursed?

A: The payment for services of non-ParPlan physicians will be the same as for ParPlan physicians.

Q: How will inequitable fee situations be resolved?

A: An appeal process is available and may be initiated through our customer service division. Such an appeal does result in review of allowance made and will consider any supporting information (such as operative notes) that the physician cares to submit. The appeals process is under the direction of the medical director and is carried out by nurses and physicians.

Q: Can complex or new procedures and techniques be preauthorized?

A: A preauthorization process is available for any procedure for which a physician chooses to request such a preauthorization.

Q: Why is precertification being used when Texas Medical Foundation (TMF) has decided to discontinue it?

A: TMF precertified a limited number of procedures. Blue Cross and Blue Shield of Texas precertification presently covers all inpatient admissions, and it has been our experience that it does result in a significant reduction in inappropriate hospital usage with a consequent savings to our premium payers.

Q: Are denials of payments reviewed by physicians and what appeals process is used?

A: All denials of reimbursement for medical reasons are reviewed by a physician prior to the denial being made. The same appeals process is available for denial of services as is available for fee disputes.

Q: How will physicians know when their patients have reached their deductibles and how much to bill for copayments, etc?

A: Our customer service division will provide deductible and copayment information to ParPlan physicians. There will be a toll-free line for ParPlan physicians to obtain this information.

ON BLUECHOICE

Q: How does BlueChoice Plan differ from a PPO?

A: BlueChoice is a PPO-based point-of-service product. The patient's primary care physician will play a key role in the management of any patient seeking in-network benefits via the BlueChoice network.

Q: How will physicians be chosen to participate in the program?

A: Physicians will be contacted who are appropriately located and of needed specialties to serve point-of-service customers. Other physicians will be permitted to submit applications for the plan should they choose to do so.

Q: What financial responsibilities do primary care physicians have for referral to specialists?

A: None.

Q: Must the patient accept the referred physician specialist? How can he or she change?

A: The primary care physician will have a full list of participating spe-

cialists. To change from one participating specialist to another will require a new referral from the primary care physician.

Q: What reimbursement methodology (capitation or discounted fee-for-service) will be used?
A: Fee-for-service.

Q: What is the difference in benefit levels for someone who goes inside the network vs outside?
A: This will vary depending on the insured group.

Q: What mechanism is used to assign physicians to patients?
A: The patient's choice.

Q: What recourse do physicians have for reassignment of patients?
A: Physicians are not required to accept any particular patient. They will be required to accept a reasonable number of point-of-service patients. ★

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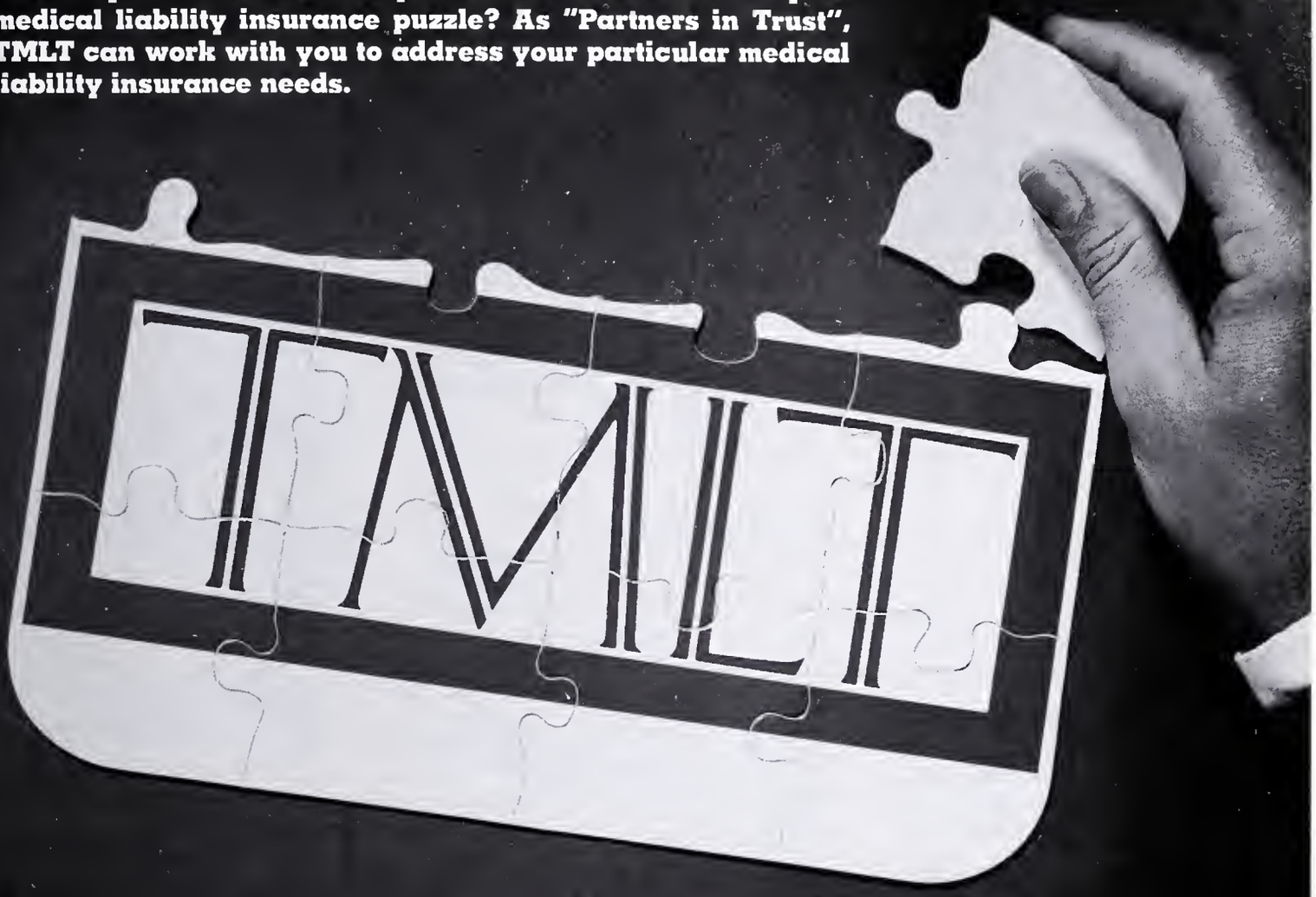

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Law

Texas illegal remuneration statute builds on previous law

Hugh M. Barton, JD
TMA Assistant General Counsel

During the 1991 Texas Legislature, a bill prohibiting physicians from accepting "illegal remuneration" was passed. Because this occurred around the time that the federal government was publishing its final "safe harbor" rules pertaining to Medicare and Medicaid, there had been speculation that the two events were somehow linked. Additionally, there have been questions regarding just what the new Texas law covers.

Q: Why did the legislature pass this new law?

A: What are now generally referred to as "kickbacks" have been illegal for Texas physicians since 1911. A statute enacted in that year was made part of the 1916 Texas Penal Code and prohibited physicians, osteopaths, masseurs, or "any other person who practices medicine, or the art of healing the sick or the afflicted, with or without the use of medicine," from paying or accepting payment from or to any person "for securing, soliciting or drumming patients or patronage." Punishment was set at a maximum fine of $200.

The law was rewritten in 1931 and transferred out of the Penal Code to the statutes concerning medical practice in 1973. Subsequently, when the Medical Practice Act was codified in 1981, the operative language was transferred to the Medical Practice Act. The primary weakness of this provision is that it does not prohibit a physician from accepting payments for securing patients from *nonphysicians*. The action of the Texas legislature in enacting the "illegal remuneration" provisions is a natural progression that plugs this loophole and reinforces ethical opinions of the AMA Council on Ethical and Judicial Affairs and the TMA Board of Councilors.

Q: What does the new "illegal remuneration" statute do?

A: The law prohibits anyone licensed, certified, or registered to provide health-care services in Texas (not just physicians) from offering to pay or agreeing to accept any remuneration from any person for securing or soliciting patients. The broad applicability extends physician ethics and prohibitions to all in the health-care field. The identity of the payor or type of patient is irrelevant, thus the act applies to worker's compensation patients, psychiatric patients, and all others under private insurance. The act does allow legitimate advertising and business promotion activities. The act does not apply to health maintenance organizations, licensed insurers, certain public entities, and group hospital service corporations.

The "illegal remuneration" statute extends physician ethics and prohibitions to all in the health-care field.

The Texas law has a provision that prohibits its application in a manner more restrictive than the Medicare law. In other words, if a business arrangement is legal under the federal Medicare laws and regulations, it is legal under the new Texas law. For example, if a business practice is protected under the federal "safe harbor" rules, it is als protected in Texas.

The statute, as currently writte provides for a Class A misdemeanc punishment. A subsequent offense punished as a third-degree felon with 2 to 10 years in prison and/or fine up to $5,000.

Q: What is Texas Medical Association ethical position on this?

A: The TMA Board of Councilor has adopted an ethical opinion o the subject of "Health Facility Owr ership by Physician[s]":

> A physician may own or have financial interest in a for-prof hospital, nursing home, or othe health facility, such as a free-stanc ing surgical center o emergency clinic. How ever, the physician has a affirmative ethical obliga tion to disclose his owne ship of a health facility t his patient, prior to ad mission or utilization.
>
> Under no circum stances may the physi cian place his own finan cial interest above th welfare of his patients The prime objective o the medical profession i to render service to hu manity; reward or financial gai is a subordinate consideration For a physician to unnecessaril hospitalize a patient or prolon or reduce a patient's stay in th health facility for the physician' financial benefit would be uneth ical. Furthermore, remuneratio should be based on capital in vestment and not on utilizatio or referral of patients to a partic ular facility.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

If a conflict develops between the physician's financial interests and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.

A physician should not be influenced in the prescribing of drugs, devices, or appliances by a direct or indirect financial interest in a pharmaceutical firm or other supplier. Whether the firm is a manufacturer, distributor, wholesaler, or repackager of the products involved is immaterial. Reputable firms rely on quality and efficacy to sell their products under competitive circumstances and do not appeal to physicians to have financial involvements with the firm in order to influence their prescribing. A physician may own or operate a pharmacy if there is no resulting exploitation of patients.

Additionally, the American Medi-al Association Council on Ethical nd Judicial Affairs has adopted pinions relating to possible onflicts of interest, fee splitting, and eferrals. The AMA has recently an-ounced a campaign to inform its embers of the December 1989 Re-ort of the Council on Ethical and udicial Affairs on the ethics of self eferral arrangements.

Legal articles in Texas Medicine *are intend-d to help physicians understand the law by roviding legal information on selected top-cs. These articles are published with the un-lerstanding that TMA is not engaged in pro-viding legal advice. When dealing with pecific legal matters, readers should seek as-istance from their attorneys.*

Limited liability partnerships offer alternative to incorporation

Helene Alt Thompson, JD
TMA Associate General Counsel

Many physicians have incorporated their practices under the Texas Professional Association Act for no other reason than to avoid personal liability for damages from successful health-care liability claims filed against other physicians in their practice (1).

As a result of the efforts of various law firms and professional groups, the Texas Uniform Partnership Act was amended by the 72nd Texas Legislature during its regular session to allow partners in general partnerships to limit their liability in professional liability lawsuits by becoming limited liability partnerships (2).

Personal liability in a professional association

The general principle of incorporation is that of limited liability, which means a shareholder is financially responsible for all the risks of the corporation business only up to the level of his or her equity in the corporation.

If your professional association (PA) or your fellow physician-member incurs a liability, you will be liable for the judgment only up to the amount of your equity in the association. For example, if the fellow physician-member is adjudged to be negligent in providing his professional care and the judgment is in excess of insurance coverage, the excess can be taken from association assets and the personal assets of the colleague against whom the judgment is rendered. Your personal assets and those of your other colleagues would be safe (3).

Personal liability in a partnership

Compare the above situation to what would happen in a normal partnership.

A professional-liability judgment would be paid first out of any available insurance. If the judgment exceeds the insurance maximum, then assets of the partnership would be taken, followed by the assets of the individual physician whose action was the basis for the suit. However, if that is not enough, the person who won the judgment can then go after the personal assets of any or all of the other partners. That is because in a partnership, as a general rule, each partner is responsible for the actions of every other partner — completely responsible, not just up to a certain percentage — as long as those actions were within the scope of the partnership (4).

Personal liability in a limited liability partnership

As of August 26, 1991, physicians in partnership with other physicians who for various reasons do not wish to incorporate may avoid responsibility for their colleagues' negligence in providing professional care by electing to become a limited liability partnership (LLP).

A partner in a registered LLP is not individually liable for debts and obligations of the partnership arising from errors, omissions, negligence, incompetence, or malfeasance committed in the course of the partnership business by another partner or a representative of the partnership not working under the supervision or direction of the first partner at the time of these acts. This is true unless the first partner was directly involved in the specific activity in which the errors, omissions, negligence, incompetence, or malfeasance

were committed by the other partner or representative; or had notice or knowledge of the errors, omissions, negligence, incompetence, or malfeasance by the other partner or representative at the time of occurrence.

Be aware that the LLP status does not affect the joint and several liability of a partner for debts and obligations of the partnership arising from any cause other than those specified above. Also, LLP status does not affect the liability of partnership assets for partnership debts and obligations (5).

LLP requirements

To become a registered LLP, a partnership must file with the secretary of state an application stating the name of the partnership; the address of its principal office; the number of partners; and a brief statement of the business in which the partnership engages. The application must be executed by a majority in interest of the partners or by one or more partners authorized by a majority in interest of the partners. The application must be accompanied by a fee of $100 for each partner. Registration is effective for 1 year after the date of the registration is filed, unless voluntarily withdrawn by filing with the secretary of state a written withdrawal notice executed by a majority in interest of the partners or by one or more partners authorized by a majority in interest of the partners.

A registered LLP's name must contain the words "registered limited liability partnership" or the abbreviation "LLP" as the last words or letters of its name.

A registered LLP must carry, if reasonably available, at least $100,000 of liability insurance of a kind that is designed to cover the kinds of errors, omissions, negligence, incompetence, or malfeasance for which liability is limited by becoming an LLP.

If the registered LLP is in compliance with the insurance requirements, the insurance requirements shall not be admissible nor in any way made known to a jury in determining the issue of liability for or extent of the debt or obligation or damages in question (6).

Protective measures

LLP status does not confer as much protection as incorporation does in that incorporation shields physician members' personal assets from nonprofessional liability claims (for example, a pharmaceutical representative slipping and falling on your doorstep) and the general debts of the corporation.

However, it does offer those physicians who find operating as a professional association too costly or impractical a way of eliminating liability that arises merely from a person's status rather than from a person's professional acts or omissions.

The American Medical Association has available a guide to corporations for physicians. For information on *A Physician's Guide to Professional Corporations* (#OP378289), contact the AMA at (800) 621-8335. The cost is $19.95 for members and $29.95 for nonmembers.

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

Childhood malignant melanoma in a patient with dysplastic nevi

Richard F. Wagner, Jr, MD

A 14-year-old boy with sporadic dysplastic nevus syndrome and an in situ malignant melanoma is described. Patients with the dysplastic nevus syndrome should be routinely evaluated for signs of malignant melanoma. When malignant melanoma is diagnosed early, chances for cure are great. However, when the diagnosis of malignant melanoma is delayed, chances for survival decrease.

Malignant melanoma is a significant health problem in Texas, and a recent estimate suggests that this disease causes about 350 deaths per year (1). If more malignant melanoma were treated in its earliest stage, many of these deaths could be prevented.

That children as well as adults are at risk for malignant melanoma is not widely recognized. Two percent of malignant melanomas occur in patients who are younger than 20 years old, and malignant melanoma represents 3% of all cancers in this younger age group (2). Recognizing malignant melanoma in children is important so that the diagnosis can be made at the earliest opportunity and the tumor can be treated definitively.

Case report

A 14-year-old boy was evaluated for a gradually enlarging pigmented lesion of the right upper arm. Several health-care professionals were aware of the lesion, but none had suggeste consultation. No other primary fam ly member had pigmented lesions.

Physical examination revealed 14-year-old boy with a dark brow plaque of the right upper arm (Fi 1). This pigmented lesion exhibite notched borders. No regional lymp nodes were palpated. The patier had multiple smaller pigmented le sions concentrated mainly on hi back (Fig 2). He also had pigmente lesions in his scalp (Fig 3).

An excisional biopsy of the lesio on the right upper arm showed malignant melanoma in situ (Fig 4 The tumor was reexcised with nar row margins. Biopsies of other pig mented lesions were consistent wit dysplastic nevi.

Discussion

When a child develops a primary cu taneous malignant melanoma, th diagnosis is often delayed. In on study about malignant melanoma i

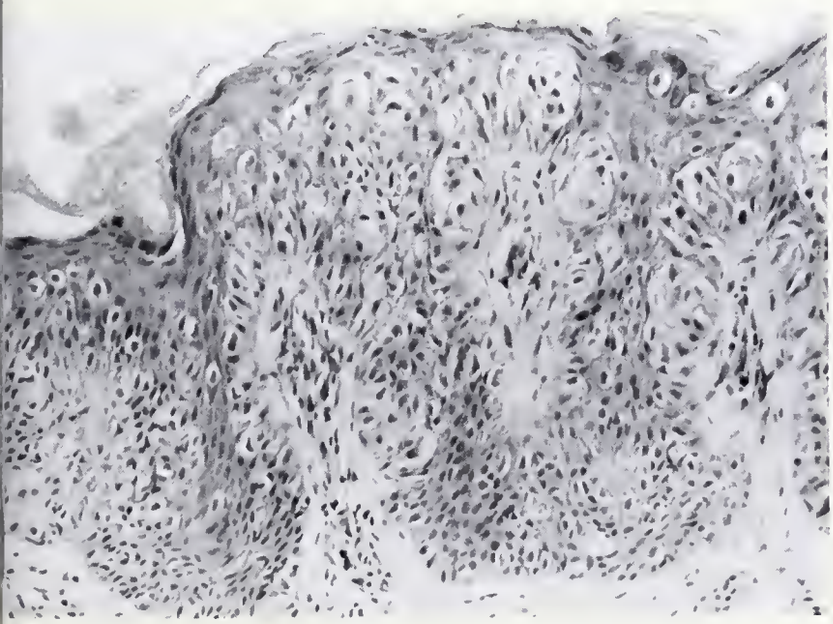
Fig 1. Malignant melanoma in situ of right upper arm (arrow).

Dr Wagner, Associate Professor, Pigmented Lesion Clinic, Division of Dermatologic Surgery and Cutaneous Oncology, Department of Dermatology, The University of Texas Medical Branch at Galveston. Send reprint requests to Dr Wagner, Department of Dermatology, G-83, The University of Texas Medical Branch, Galveston, TX 77550.

2. Multiple dysplastic nevi of back.

3. Dysplastic nevus of scalp.

g 4. Malignant melanoma in situ (hematoxylin and eosin, high power).



children and adolescents, a delayed diagnosis was most frequently attributed to physicians' failure to recognize this condition after patients sought medical attention (3). Fortunately for the patient described in this report, the malignant melanoma was still at its earliest stage when definitive surgery was performed. The prognosis is excellent for malignant melanoma when it is treated in its in situ stage.

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Years of potential life lost: an evaluation of premature cancer deaths in Texas from 1981 through 1988

TIM RAINBOLT

Death rates are traditional public health measures used to assess the health status of a population. Several types of cancer are examined in this report, and the indicator for years of potential life lost is used to estimate the number of years of life lost per disease type in Texas during the years from 1981 through 1988. For both males and females, the resulting ranking of cancer types was quite different from those obtained with death rates. Among males, testicular cancer and Hodgkin's disease ranked first and second for years of potential life lost while lung cancer and colorectal cancer ranked first and second for deaths. Most men who die with testicular cancer are young, with each death representing an average of 42 years of life lost. Among females, each death from four cancer types — leukemia, brain, cervix uteri, and malignant melanoma skin — results in more than 20 years of lost life.

Mr Rainbolt, Assistant Epidemiologist, Cancer Registry Division, Texas Department of Health, 1100 W 49th St, Austin, TX 78756-3199. Send reprint requests to Mr Rainbolt.

CANCER IS THE SECOND leading cause of death in the nation and in Texas. Death rates are often used to assess the impact of this disease and others. These rates are traditional public health measures used to describe the health status of a population and to guide policymakers in determining allocation of resources for research and treatment.

Although most cancer deaths occur at older ages, more years of life are lost when the death occurs at younger ages than expected. The use of death rates only places an exaggerated emphasis on cancer types that are primarily a major cause of death in the elderly. Thus, traditional analyses of cancer data may result in a decreased emphasis on some preventable or curable cancers that cause premature death in the young.

Studying years of potential life lost (YPLL) and years of potential life lost per death (YPLL/D) in cancer patients affords two alternative ways to analyze mortality data. Unlike conventional mortality measure these indicators emphasize mortali occurring in the younger age group The study reported here analyze cancer mortality among Texans usi these two indicators and contraste these results with traditional me sures of cancer mortality.

METHODOLOGY AND DATA

For an individual, the YPLL was ca culated by taking the difference b tween average life expectancy an age at time of death. For example, a person died at age 34 and the ave age life expectancy was 65, th YPLL (65 minus 34) would be 3 To calculate the total YPLL, the i dividual YPLL numbers wer summed for each type of cance death. To calculate YPLL/D, the t tal YPLL figure was divided by th total number of deaths for each ca cer type. This value is the averag number of years lost per individual.

According to the Centers for Di ease Control, Americans have an a

Table 1. Cancer in Texas males, aged 0 through 74 years, ranked by number of deaths and b years of potential life lost per death from 1981 through 1988.

Rank	Type of Cancer	No. of Deaths	Rank	Type of Cancer	Years of Potential Life Lost per Death
1	Lung	28,548	1	Testicular	42.0
2	Colorectal	6,423	2	Hodgkin's	28.2
3	Prostate	4,429	3	Leukemia	24.1
4	Pancreas	3,425	4	Brain	22.9
5	Urinary tract	3,013	5	Melanoma skin	21.5
6	Leukemia	2,988	6	Non-Hodgkin's	19.0
7	Non-Hodgkin's	2,417	7	Oral cavity	14.4
8	Stomach	2,140	8	Liver	14.8
9	Brain	2,105	9	Stomach	13.9
10	Esophagus	1,844	10	Esophagus	13.6
11	Oral cavity	1,818	11	Urinary tract	13.3
12	Liver	1,554	12	Colorectal	13.0
13	Melanoma skin	1,156	13	Pancreas	12.7
25	Hodgkin's	417	14	Lung	12.6
29	Testicular	197	15	Prostate	7.9
Total		62,474		Average	14.0

ble 2. Cancer mortality in Texas females, aged 0 through 74 years, ranked by number of aths and by years of potential life lost per death from 1981 through 1988.

nk	Type of Cancer	No. of Deaths	Rank	Type of Cancer	Years of Potential Life Lost per Death
	Lung	12,157	1	Leukemia	24.3
	Breast	11,225	2	Brain	22.8
	Colorectal	5,053	3	Cervix uteri	22.2
	Ovarian	3,219	4	Melanoma skin	21.9
	Pancreas	2,534	5	Breast	17.7
	Leukemia	2,127	6	Non-Hodgkin's	15.4
	Cervix uteri	1,758	7	Ovarian	14.8
	Non-Hodgkin's	1,722	8	Stomach	14.7
	Brain	1,598	9	Oral cavity	14.3
	Urinary tract	1,399	10	Urinary tract	14.0
	Stomach	1,207	11	Lung	13.2
	Multiple myeloma	902	12	Colorectal	12.8
	Corpus uteri	746	13	Corpus uteri	11.4
	Melanoma skin	738	14	Multiple myeloma	11.2
	Oral cavity	736	15	Pancreas	11.1
tal		47,121		Average	15.6

age life expectancy of 75 years (1). his value was used as the end point the analyses for both men and omen. The number of deaths per ear for the period 1981 through 988 was obtained from the Bureau f Vital Statistics, Texas Department f Health (2).

ESULTS

ables 1 and 2 show the number of eaths and YPLL/D among males nd females in Texas from 1981 hrough 1988. The data are arranged in descending order for each ype of cancer. Overall, rankings ordered by YPLL/D are quite different han those ordered by deaths.

As shown in Table 1, lung cancer 28,548 deaths), colorectal cancer 6,423 deaths), prostate cancer 4,429 deaths), and pancreatic cancer (3,425 deaths) account for 41% f all cancer deaths and for 521,689 PLL. These types constitute the our leading causes of cancer deaths mong Texas males whose ages ranged from birth through 75 years during the period 1981 through 1988. These four leading types of mortality are reversed, however, when YPLL/D are examined. Under YPLL/D, testicular cancer representing 42 years of lost life and Hodgkin's disease representing 28.2 years of life lost rank first and second, followed by leukemia (24.1) and brain cancer (22.9). Comparatively, lung cancer and prostatic cancer, which rank first and third under cancer deaths, yield YPLL/D values of 12.6 and 7.8, respectively. Like testicular cancer, Hodgkin's disease exhibits low rankings (next to last) in total cancer deaths; however, as noted above, the YPLL/D for Hodgkin's disease (28.24) is second only to testicular cancer. Leukemia maintains the highest rankings in both measures, sixth in deaths, and third in YPLL/D. Leukemia also has the highest combined total of deaths, YPLL, and YPLL/D. For the 8-year period, 2,988 males died from leukemia with a YPLL total of 71,884. The YPLL/D was 24.06.

As shown in Table 2, lung cancer (12,157 deaths), breast cancer (11,225 deaths), colorectal cancer (5,053 deaths), and ovarian cancer (3,219 deaths) account for 37% of all cancer deaths and for 471,474 YPLL. These types constitute the four leading causes of cancer death among Texas women whose ages ranged from birth through 75 years during the period 1981 through 1988. Under YPLL/D, leukemia (representing 24 years of lost life) and brain cancer (22.3 years) rank first and second, followed by cervix uteri (22.2 years) and malignant melanoma (21.5 years). Leukemia, the cancer with the highest YPLL/D in females, is also highly ranked by number of deaths (sixth). This is not comparable in males. Breast cancer has the highest rankings in the two indexes, second in deaths and fifth in YPLL/D. Breast cancer also had the highest combined total of deaths, YPLL, and YPLL/D. For the 8-year period, 11,225 females died from breast cancer with a YPLL total of 197,635. The YPLL/D was 17.6.

Discussion

Conventional methods for measuring cancer mortality that use number of deaths and death rates provide important information for the targeting of limited public health funds. However, less conventional measurements that provide information in terms of premature death can be used also to evaluate the impact of various types of cancer. For example, among males, testicular cancer is by far the leading cause of premature cancer death. Also, Hodgkin's disease, leukemia, brain cancer, and malignant melanoma contribute significantly to premature

cancer death. Furthermore, testicular cancer (8,274 YPLL), Hodgkin's disease (11,759 YPLL), and malignant melanoma (24,854 YPLL) have high survival rates, especially when diagnosed during the early stages of the disease. According to the National Cancer Institute, among white males during the years 1981 through 1986, the 5-year relative survival rate for all stages of testicular cancer, Hodgkin's disease, and malignant melanoma measured 92%, 75%, and 76%, respectively. This suggests that if further emphasis were placed on education, self-examination, and presymptomatic checkups, diagnoses would be made earlier and the 5-year relative survival rates would be even higher.

Among females, cervical cancer (39,028 YPLL) and malignant melanoma (16,162 YPLL) represent the third and fourth leading causes of premature cancer death. Again, these cancers have encouraging survival rates, especially when the diseases are diagnosed during the early stages. From 1981 through 1986, the 5-year relative survival rate among white females for all stages of cervical cancer and malignant melanoma measured 67% and 86%. Also, although not applicable for testicular cancer and Hodgkin's disease in males, life-style risk factors have been identified for both cervical cancer and malignant melanoma. These cancers should be public health priorities because many deaths can be prevented by simple practices. The Pap smear is an inexpensive screening procedure for cervical cancer. Estimates suggest that up to 90% of invasive cervical cancers could be prevented by screening at 3-year intervals. To prevent malignant melanomas, persons who spend time in the sun should wear protective clothing and use sunscreen.

Like cervical cancer and malignant melanoma, breast cancer responds favorably to treatment when diagnosed during the early stages. For cases diagnosed during the localized stages from 1974 through 1986 the 5-year relative survival rate measured 91% for women younger than 50 years and 89% for women aged 50 and older; in contrast, among cases diagnosed during the distant stages, the 5-year relative survival rate measured 18% for women younger than 50 and 21% for women aged 50 and older. Mammography can play a major role in detecting breast cancer at an early stage. Estimates suggest that screening mammography would have detected 4,620 (60%) of an estimated 7,700 cases of breast cancer that occurred among Texas females in 1990 (3,4).

For males and females combined, leukemia maintained the highest rankings for the three indexes analyzed. Under deaths, leukemia ranked sixth for both males and females. Under YPLL, leukemia ranked third for males and fourth for females. Under YPLL/D, leukemia ranked third among males and first among females. From 1981 through 1988, a combined total of 5,115 leukemia deaths occurred with a total of 123,585 YPLL. The combined YPLL/D indicate that for every leukemia death that occurs among males and females, an average of 24 years of life is lost. At present, risk factors for leukemia are diagnostic, therapeutic, and occupational exposure to ionizing radiation and benzene. Exposure to vinyl chloride and genetic susceptibility may also play a role in the etiology of leukemia. Our finding supports the need for more epidemiologic studies designed to further examine these risk factors.

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Three cases of alpha$_1$-antritrypsin deficiency: a review of diagnostic and therapeutic strategies

Douglas W. Jenkins, MD

eficiency of alpha$_1$-antitrypsin is unusual cause of emphysema. his deficiency may be suspected hen the age of onset and severity disease are out of proportion to e history of inhaled agents (usual- cigarette exposure). Three pa- nts seen during a relatively short ne in a private practice underscore e variability of presentation. Prop- diagnosis offers such patients sev- al benefits, particularly in view of w potential therapies.

r Jenkins is in private practice with the inner Clinic, San Antonio, Tex. Send print requests to Dr Jenkins, 124 Dallas St, n Antonio, TX 78205.

Deficiency of alpha$_1$-antitrypsin (AAT) was described in 1963 by Laurell and Eriksson (1). Since that time, the inheritance and manifestations of a large number of alleles at the proteinase inhibitor (Pi) locus have been the subject of much study (2). Those alleles associated with very low levels of antitrypsin (commonly ZZ, SZ, or the rare null-null) have been associated with early onset of severe emphysema. The clinical characteristics are far from uniform, and the severity of the disease depends on cigarette smoking and other unknown factors (3). Within the past several years, treatment by specific replacement of AAT (4,5) and by lung transplantation has become available. Thus, proper identification of affected individuals allows not only a firm diagnosis and appropriate counseling (as in any genetic disease), but now may open the possibility of improved therapy. The great variability of presentation among three patients seen recently in a private practice underscores the sometimes "concealed" nature of the diagnosis.

Case 1

A 43-year-old man with severe emphysema was referred in February 1988. He had a history of progressive dyspnea, with emphysema first diagnosed in 1981. With several brief exceptions, he had not smoked for 8 years. Pulmonary function testing showed an FEV_1 (forced expiratory volume in the first second) of 0.65 L (16% of predicted) and an FVC (forced vital capacity) of 1.3 L (25% of predicted). The FEV_1/FVC ratio was 50% (predicted 80%). These values were interpreted as showing severe obstruction and severe functional impairment. The level of AAT in serum was 0.2 g/L (normal 0.8 to 2.1 g/L). With these far-advanced changes, the patient was referred to The University of Texas Health Science Center at San Antonio. Over the next few months, his condition continued to deteriorate. In January 1989, he underwent single-lung transplantation. After doing very well initially, he experienced a slow deterioration in the function of the transplanted lung that necessitated transplantation of the contralateral lung in December 1990. As of this writing, the patient is reported as stable with improved symptoms of dyspnea (6).

Case 2

A 77-year-old woman was self-referred for exertional dyspnea in January 1989. She had noted these symptoms for approximately 8 years. The patient had never smoked. One brother (of 11 siblings) was reported to have died at age 52 from asthma and emphysema. Pulmonary function tests showed an FEV_1 of 0.98 L (41% predicted), an FVC of 2.03 L (61% predicted), and an FEV_1/FVC ratio of 48% (predicted 71%). The AAT level was 0.3 g/L, and a serum protein electrophoresis confirmed the absence of significant alpha$_1$ protein. The patient and family were given the diagnosis and information regarding inheritance and testing. The patient was subsequently lost to follow-up.

Case 3

A 32-year-old male was self-referred in May 1989 and related a history of mild occupational exposure to chlorine gas. He seemed more affected than several other workers who suffered the same exposure. Immediately after the incident, he had been hospitalized for observation and

told he had impaired pulmonary function and a low level of oxygen in the blood. On the advice of his physicians at that time, he quit his previous habit of smoking one-half pack of cigarettes per day. Pulmonary function testing showed an FEV_1 of 2.68 L (60% predicted), an FVC of 4.19 L (73% predicted), and an FEV_1/FVC ratio of 64% (predicted 78%). Additional studies included an AAT level of 0.2 g/L. The patient was referred to a medical center that had the potential to replace AAT. Since then, he has been lost to follow-up.

Comment

Deficiency of AAT has provided a marvelous biochemical insight into human disease. Evolving from the discovery of this rare genetic disease has been a generalized theory of the pathogenesis of emphysema. The elastase/antielastase concept is now well established in pulmonary medicine. The architecture of the lung is maintained by a balance of potential autodigestion (elastase) and self-regulation (antielastase). Although commonly termed antitrypsin, the better term for $alpha_1$-globulin might actually be antielastase. The failure of this self-regulatory system in favor of autodigestion because of genetic or environmental factors leads to emphysema. The specifics of this field have been reviewed elsewhere (1–5).

In general, a normal individual is homozygous for the M gene (MM). Individuals who are homozygous for the most common abnormal gene (ZZ) are at risk for early development of emphysema. The range of pulmonary abnormalities in the ZZ individual is very broad; clearly, many individuals do not develop significant lung disease. The reasons for this variability are not known. Heterozygotes (MZ) usually do not develop clinical disease but may be properly advised to reduce environmental insults.

The AAT level can be determined by many reference laboratories, and this determination is probably the most cost-effective test. Levels below 0.8 g/L (or less than 11 μM using newer standards) represent significantly low levels. The serum protein electrophoresis is usually more expensive than direct determination of AAT, and electrophoretic findings should be reviewed by a knowledgeable person to avoid certain problems in densitometry that may lead to the false presumption that adequate levels of AAT are present. Referral should be arranged if the initial levels are questionable. The company producing the AAT replacement product (Prolastin) now offers a free testing service to the patient (8).

The availability of AAT replacement therapy offers possible treatment to selected patients with AAT deficiency. Expense is a major factor at this time, as is the necessity for intravenous administration two to four times per month. Those patients with far-advanced disease and those with nearly normal pulmonary function would clearly not be expected to benefit from replacement. Those patients who are "in between" are currently best considered for therapy. Guidelines for replacement therapy have been described (4,5,9).

Because of the number of years involved in the development of AAT-related emphysema and because of wide individual variability, the classic double-blind study of replacement therapy will never be completed in one investigator's lifetime. Rather we must depend on careful clinical observation to arrive at a propriate conclusions. To that end national registry has been esta lished by the Division of Lung D ease of the National Heart, Lu and Blood Institute. This registry not aimed at therapeutic interve tion, but will provide formal da gathering and follow-up. Cente have been selected around the cou try (9). The participating instituti in Texas is in Tyler: The Universi of Texas Health Science Cent Tyler, PO Box 2003, Tyler, T 75710, (214) 877-3451 (James M Stocks, MD, and Allen Cohen, MD Referral can be discussed with the physicians by phone. The impact the patient is relatively slight a consists essentially of an annual f low-up examination.

Any patient receiving a first-tin diagnosis of emphysema should ha confirmation by pulmonary functi testing to avoid confusion with ot er causes of dyspnea. When the r sult of the pulmonary function test indeed abnormal, an AAT te should be strongly considered. Th test needs be done only once in ea patient's lifetime and has the pote tial to increase diagnostic precisi and to provide important therape tic options.

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Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request.

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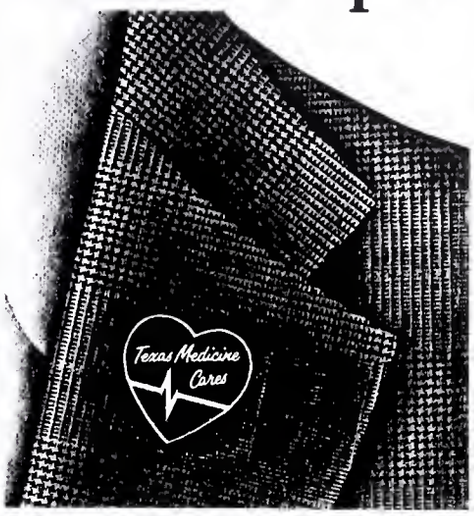

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culty Positions — Department of Family Medicine, xas Tech Regional Academic Sciences center in Amar- o is seeking board eligible/board certified family ysicians at Assistant or Associate Professor level. sponsibilities include clinical practice, teaching third ar medical students, teaching residents, administra- ns and research. Faculty development opportunities ailable for those without prior teaching experience. cellent fringe benefits. Salary commensurate with ex- rience. Send CV to C.V. Wright, MD, Department of mily Medicine, 1400 Wallace Blvd., Amarillo, TX 106. Texas Tech is an equal opportunity/affirmative tion employer.

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Family Practice - Beaumont, TX. SSG needs associate to run satellite clinic in affluent suburb. $120K+ income guarantee, plus benefits. For details contact Practice Dynamics, 11222 Richmond, Ste 125, Houston, TX 77082, 800 933-0911 or 713 531-0911.

Internal Medicine

Gold Mine for Internist — Wanted, aggressive and energetic physician, BE/BC to do consultations for a group of family physicians. Must be able to do procedures. Very competitive fee for service income available, including benefits. Salary is based on percentage of collections with a base salary guarantee. Send CV to Nancy Bloomfield, 4010 College St., Suite 200, Beaumont, TX 77707.

Progressive internist needed — Central Austin, Texas. Fully-staffed and furnished attractive office space. Affability, flexibility, and personality a must. Unbeatable deal, very flexible, Anita Bradley, Office Manager, 512 477-3282.

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OB/GYN

Expanding 15-physician multi-specialty group has excellent opportunity for an OB/GYN physician in friendly West Texas community of 25,000. Adjacent to a 153-bed modern hospital. Excellent guaranteed salary with no first year expenses in addition to benefits. Moving allowances also available. Direct inquiries or send CV to Gail Knous, Malone and Hogan Clinic, 1501 W. 11th Place, Big Spring, Texas 79720 (915) 267-6361.

SOUTH TEXAS

Obstetrician/Gynecologist, board eligible or certified, to join an incorporated practice of 2 board certified Ob/Gyns. Subtropical Gulf Coast area with excellent water sports, hunting and fishing all year round. Gender no barrier. Excellent salary, full range of benefits. Send CV to Ad Box 785/Advertising, 401 West 15th, Austin, TX 78701.

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FORT WORTH
Anesthesiologists needed to join group practice serving 429-bed teaching hospital experiencing 5,000+ cases per year. Full range of anesthesia required (excluding hearts); supervise CRNAs. This position offers attractive life style with limited call. Contact: Barry Strittmatter.

NORTH CENTRAL TEXAS
Regional medical center in community of approximately 24,000 (serving referral area of 195,000) seeks anesthesiologist to perform full range of anesthesia services, including hearts. Shared call, modern facilities. Area renown for recreational opportunities. Competitive income guarantee to qualified physician. Good location; accessible to D/FW Metroplex. Contact: Vicki Truitt.

CARDIOLOGY

NORTHEAST TEXAS
Cardiology group seeks BE/BC invasive cardiologist for associate practice in NE Texas community. Referral area of 200,000. Modern medical facilities in town with more than 100 physicians. Progressive, family-oriented community with strong diversified economy, excellent schools. Many social and recreational opportunities. Generous compensation and benefits to high caliber physician.
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DIAGNOSTIC RADIOLOGY

PANHANDLE
Excellent private practice opportunity for BC/BE radiologist desirous of living in a community with good quality of life; great place to rear children. New hospital with modern equipment, including CT. Well trained supportive medical community. Generous incentive package to qualified candidate.
Contact: Jim Truitt.

FAMILY PRACTICE

FORT WORTH
Correctional health services opportunity available in Tarrant County. Orchestrate and supervise activities of professional health care team. Regular hours, limited call; good income and benefits.
Contact: Vicki Truitt.

CENTRAL TEXAS
A young, well-established family practice group and well-equipped, financially sound JCAHO accredited hospital are looking for two BC FPs to handle increasing patient volume. Located in Central Texas, eight miles from a major lake and 18-hole golf course/country club, this opportunity offers an outstanding life style to the physician who wishes to practice a full range of family medicine. Competitive incentive package available to qualified physician. Contact: Barry Strittmatter.

FORT WORTH
Single specialty group and solo practice options available for board certified family practitioner with well-established Metroplex hospital. Competitive incentive package will be offered to qualified candidates. Contact: Barry Strittmatter.

HIGH PLAINS
Young well-trained BC FP seeks compatible FP associate for rapidly expanding family practice; includes OB. Community of 5,000 with service area of approximately 15,000. Excellent quality of life; good schools. Abundant outdoor recreational opportunities available, including nearby lake. City of 200,000 within 45 minutes. Generous financial package will be offered to qualified candidates. Contact: Jim Truitt.

GASTROENTEROLOGY

NORTHEAST TEXAS
Three busy gastroenterologists seek fourth associate for group practice in NE Texas. Shared call, comprehensive benefit package, early partnership. Modern office and hospitals. Attractive community with strong, diversified economy, excellent schools. Many social and recreational opportunities.
Contact: Vicki Truitt.

INTERNAL MEDICINE

PANHANDLE
Excellent private practice opportunity for I physician in community of 8,000 (service a 20,000). New hospital with state of the art diag equipment. Well-trained medical staff suppor this effort. Many outdoor recreational opport available. Good school system. Excellent qu life. Generous incentive package.
Contact: Jim Truitt.

NORTHEAST TEXAS
Two internists seek third associate for busy p in NE Texas community of 27,000 (referral a 200,000+). Progressive, family-oriented com with strong, diversified economy. excellent sc Social and recreational opportunities ab Modern medical facilities. Shared call; attr incentive package. Contact: Jim Truitt.

AMARILLO
Busy BC IM seeks associate for rapidly gr practice. Fully equipped office facilities. 35 hospital offering competitive incentive pac Excellent schools and quality of life; four s climate. Ideal location for outdoor sports enthi Easy access to snow and water skiing, bo fishing, etc. Contact: Jim Truitt.

SOUTH TEXAS
Thirty minutes from Padre Island. IM g specializing in critical care, seeks fourth comp associate. Great climate and lifestyle. Recrea opportunities abound. Excellent income pot Contact: Barry Strittmatter.

NEUROLOGY

NORTHEAST TEXAS
Regional medical center serving 200,000 s BE/BC neurologist for practice; fee for se shared call. Modern medical facilities. 100+ d in town. Progressive, family-oriented communit strong, diversified economy, excellent schools. social and recreational opportunities. Gen incentive package to qualified physician.
Contact: Barry Strittmatter.

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esource Network

TETRICS/GYNECOLOGY

THEAST TEXAS
nal medical center serving 200,000 seeks OB/Gyn for private practice (to share call with other OB/Gyns). Progressive, family-oriented nunity with strong, diversified economy, lent schools. Many social and recreational tunities. Competitive incentive package to ed physician. Contact: Jim Truitt.

OLOGY

THEAST TEXAS
logy group seeks BE/BC medical oncologist for ciate practice in NE Texas community with al area of 200,000. Modern medical facilities in with more than 100 physicians. New cancer r under construction. Progressive, family-ed community with strong, diversified economy, llent schools. Many social and recreational tunities. Generous compensation and benefits h caliber physician. Contact: Jim Truitt.

T WORTH
ime, medical oncology position at teaching tal in D/FW Metroplex. Opportunity to direct on; develop full time oncology teaching service; with house staff. Modern facilities; infusion lab. lar hours and limited call. Competitive income benefits. Contact: Vicki Truitt.

OLARYNGOLOGY

THEAST TEXAS
onal medical center serving 200,000+ seeks tional otolaryngologist for private practice rtunity. Share call with recently trained BC Progressive, family oriented community with ng, diversified economy, excellent schools. y social and recreational opportunities. petitive incentive package to qualified physician. act: Jim Truitt.

DIATRICS

RTHEAST TEXAS
amic group of American trained BC pediatricians fourth associate for group practice in attractive munity of 27,000 (referral area of 200,000). gressive, family-oriented community with strong, rsified economy, excellent schools. Social and eational opportunities abound. Modern hospital Level II nursery and designated pediatric care Shared call; excellent income and benefits; partnership. Contact: Vicki Truitt.

NORTH CENTRAL TEXAS
Recently trained, BC female pediatrician seeks compatible associate for private practice. Share call with three other pediatricians. Competitive income and benefits. Attractive area with easy access to Dallas. Contact: Vicki Truitt.

SURGERY

SOUTH TEXAS
Within one hour of San Antonio. South Texas community seeks general surgeon for service area of 200,000. Candidate should be willing to do some primary care, initially. Hunting, fishing (fresh and salt water) and other recreational activities abound. Forty-two bed hospital will offer generous incentive package to qualified candidate.
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NORTHEAST TEXAS
Regional medical center serving 200, 000+ seeks vascular surgeon for private practice opportunity of 27,000. Progressive, family-oriented community with strong, diversified economy, excellent schools. Many social and recreational opportunities. More than 100 doctors in town. Shared call; competitive incentive package to qualified physician.
Contact: Jim Truitt.

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Pediatric

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A Pediatrician is needed to establish practice in a medical complex next to our 160-bed hospital in the high-growth section of Abilene. This is an opportunity to establish a thriving practice with an attractive support package from our hospital. For more information send your CV to: Gordon Crawford, Manager, Professional Relations Humana, Dept. II-1F, P.O. Box 1438, Louisville, KY 40201-1438. Or call TOLL-FREE 1-800-626-1590.

Pediatrics — Bay City, TX is recruiting to sponsor a third pediatrician in town. Competitive income guarantee and relocation package. Stable economy, casual lifestyle. For details contact Practice Dynamics, 11222 Richmond, #125, Houston, TX 77082; 800-933-0911 or 713 531-0911.

BC/BE Pediatricians — Excellent Opportunity. Clinica Medica Familiar is the largest multi-office, multispecialty medical group serving the Spanish speaking community in Southern California. Salary $95K to 120K plus benefits and incentive program. Bilingual -Spanish/English preferred. Call 213 261-1290.

B/C Pediatrician — Hospital Based. Small community hospital is seeking B/C Pediatrician for excellent opportunity. Salary $95K to $120K plus excellent benefits and incentive program. Bilingual-Spanish/English preferred. Call 213 261-1290.

Physiatrist

College Station, Texas — In August 1990 the community's first Physiatrist established practice here and he is already overwhelmed. Another Physiatrist is now needed to associate. Our hospital here established a Physical Medicine & Rehabilitation Institute, with water therapy, this summer. Send CV to: Gordon Crawford, Professional Relations, Humana Inc., Dept. II-1B, PO Box 1438, Louisville, KY 40201-1438, Or call Toll Free 1-800-626-1590.

Primary Care

Primary Care Houston — Workman's comp/personal injury clinic needs associate. Income based on productivity; full benefits. Should make $120,000-$180,000 per year. No weekend, no call. For details contact Practice Dynamics, 11222 Richmond, #125, Houston, TX 77082; 800-933-0911 or 713-531-0911.

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Radiology — Immediate opening for BE/BC Radiologist in Dallas area outpatient practice. All modalities, mostly neuroradiology. Send CV to PHYMED Imaging, 9 White Rock Trail #100, Dallas, TX 75238.

Expanding 15-Physician multi-specialty group has ex lent opportunity for a radiologist in friendly West Te community of 25,000. Adjacent to a 153-bed mod hospital. Excellent guaranteed salary with no first y expenses in addition to benefits. Moving allowa also available. Direct inquiries or send CV to (Knous, Malone & Hogan Clinic, 1501 W 11th Place, Spring, TX 79720, 915 267-6361.

Houston Radiologist — looking for associate. Flexi work schedule. 25–30 hours weekly. Hospital ba practice, no buy in for partnership. For further infor tion, contact Jerry Lewis, 1-800-666-1377.

Radiologist Houston — Group in Medical Center add associate. Must have MRI experience. Salary plus benefits leading to partnership. For details cont Practice Dynamics, 11222 Richmond, #125, Houst TX 77082; 800-933-0911 or 713 531-0911.

Diagnostic Radiologist with CT, MR, Interventional, U Nuclear Medicine skills to join group of 7 Board Ce fied Radiologists. Two hospitals, private offices, s vice to nearby communities. Centrally located to S Antonio, Austin, Houston, Corpus Christi. Good fan environment. Contact James Neumann, M.D., B 3610, Victoria, TX 77903 512 578-0317.

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or send CV: 11140 Westheimer
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Houston, TX 77042
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Position Available — Seeking BC/BE Family Practic General Internist, Edocrinologist, OB/GYN to join esta lished multi-specialty clinic. Excellent benefits and gu antee. Send CV to Leroy W. Kitch, Administrator, Sk ner Clinic, 124 Dallas St., San Antonio, TX 78205.

Practice opportunities available in communities within 6 mile radius of Tyler, Texas. Both clinic and/or hospit opportunities. Affiliation with multi-hospital syste based in Tyler. Send resume to P.O. Box 908, Mineol Texas 75773, or phone 1-800-828-8151.

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IM/FP Doctor to join 3 person group in Houston suburl Good hours, good salary, partnership potential. For fu ther information contact Jerry Lewis, The Lewis Grou @ 1-800-666-1377.

Corpus Christi — A three-physician group here is seekin to add a fourth member. Attractive salary, fringe ben fits with partnership negotiable after the first yea Also, due to the rapid expansion of Humana Healt Care Plan, physicians are needed to establish privat practices in offices next to our 271-bed hospital. Th successful candidate will be offered an income guara tee, marketing support and other financial assistance

: more information, send CV to: Gordon Crawford, nager, Professional Relations, Humana Inc., Dept. II-PO Box 1438, Louisville, KY 40201-1438. Or call L-FREE 1-800-626-1590.

Houston — Join three physician group on SW side town. First year income potential in excess of)0,000. Buy-in required for partnership. For details, tact Practice Dynamics, 11222 Richmond, #125, ston, TX 77082; 800-933-0911 or 713 531-0911.

The Impaired Professional
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stin - IM and FP to join Health Department primary re group practice. Diverse patients. Mostly clinic-sed. Little call. STD, prenatal, wellchild clinic oppor-ities. Hospital and resident teaching with affiliated sidency programs. Competitive salary, benefits. Dr. e, ATCHD, 15 Waller St., Austin, 78702, 512 469-01.

ibulatory Surgery Center in Dallas Texas seeking /BE internist or family practitioner to perform pre-op ysical and to monitor pre-op patients. No weekends, ll or evenings required. Salary 80K plus benefits. nefit package includes medical, dental, and malprac-e insurance. Please send CV and photo to Dr. Whit-an, 12308 Shiremont Dr., Dallas, Texas 75230.

ysicians for Nationwide Travel. Health research organi-tion seeks physician for National Health & Nutrition amination Survey sponsored by the US Public Health rvice. Individual will be part of a large medical team nducting health examinations in govt. mobile exam nters traveling to 88 areas of the US through 1993. ust be licensed in one state. One year minimym com-itment and FULL-TIME CONTINUOUS TRAVEL RE-UIRED. Competitive salary, paid malpractice, per em, car, four weeks paid vacation per year, holidays, d health, life, dental, disabiltiy insurance offered. all Beverly Geline, 800 937-8281, ext 8248. WESTAT, C., Rockville, MD EOE/MF/V/H.

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athologist, AP, CP, FP Certified recent surgical patholo-y fellowship Texas license. 9 years experience Foren-c. Available July, 1992. Contact Arthur Copeland, #3F, 5 West 96 Street, New York, New York 10025.

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CME / Continuing Education Directory

Courses

FEBRUARY

Anesthesiology

Feb 27–Mar 1, 1992
Texas Anesthesia Conference for Obstetrics and Pediatrics. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

Cardiology

Feb 3–5, 1992
Cardiovascular Conference. Snowshoe, WVa. Contact American College of Cardiology, Extramural Programs, Dept 5080, Washington, DC 20061-5080 (1-800) 897-5400

Feb 12–15, 1992
Cardiovascular Conference. Snowbird, Utah. Contact American College of Cardiology, Extramural Programs, Dept 5080, Washington, DC 20061-5080 (1-800) 897-5400

Feb 14–16, 1992
Advances in Diagnostic and Therapeutic Cardiac Catheterization. Orlando, Fla. Contact American College of Cardiology, Extramural Programs, Dept 5080, Washington, DC 20061-5080 (1-800) 897-5400

Computer Applications

Feb 22, 1992
GRATEFUL MED: Computer Access to Information. Austin. Contact Texas Medical Association Library, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1547

Emergency Medicine

Feb 21–22, 1992
Advanced Cardiac Life Support. Temple. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Feb 21–22, 1992
Advanced Pediatric Life Support. Houston. Contact American College of Emergency Physicians, PO Box 619911, Dallas, TX 75261-9911 (1-800) 798-1822 or (214) 550-0911

Feb 21–22, 1992
Emergency Medicine Review. Austin. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Feb 22–24, 1992
Managing Your Emergency Department. La Jolla, Calif. Contact American College of Emergency Physicians, PO Box 619911, Dallas, TX 75261-9911 (1-800) 798-1822 or (214) 550-0911

Internal Medicine

Feb 21–22, 1992
Advances in Gastroenterology. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

Neurology

Feb 13–15, 1992
Recent Advances in Neurology. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm Ls-105, San Francisco, CA, 94143-0742 (415) 476-4251

Pathology

Feb 13–16, 1992
Cytopathology Review Course. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

Feb 24–26, 1992
Fine Needle Aspiration Basic Tutorial. Squaw Valley, Calif. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm Ls-105, San Francisco, CA, 94143-0742 (415) 476-4251

Feb 27–29, 1992
Fine Needle Aspiration Advanced Tutorial. Squaw Valley, Calif. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm Ls-105, San Francisco, CA, 94143-0742 (415) 476-4251

Psychiatry

Feb 1–2, 1992
Divorce and Remarriage in the 90s: The Role of the Professional. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

Feb 29, 1992
Geriatric Psychiatry Review. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Sports Medicine

Feb 2–9, 1992
Office Based Sports Medicine. Duran Colo. Contact University of California San Francisco, Extended Programs in M ical Education, Rm Ls-105, San Francis CA, 94143-0742 (415) 476-4251

MARCH

General Medicine

Mar 7, 1992
Geriatrics for the Primary Care Physici Dallas. Contact St Paul Medical Cent Office of CME, 5909 Harry Hines Bl Dallas, TX 75235 (214) 879-3789

Neuroscience

Mar 3–4, 1992
Symposium on Neuroscience. Dallas. Co tact The University of Texas Southweste Medical Center, Office of CME, 5323 H ry Hines Blvd, Dallas, TX 75235 (21 688-2166

Ob-Gyn

Mar 28, 1992
Current Clinical Practice in Ob-Gyn. D las. Contact St Paul Medical Center, Offi of CME, 5909 Harry Hines Blvd, Dall TX 75235 (214) 879-3789

Ophthalmology

Mar 6–7, 1992
Ophthalmology Symposium. Dallas. Co tact Presbyterian Healthcare System, Offi of CME, 8160 Walnut Hill Ln, Dallas, T 75231 (214) 891-2323

Mar 12–13, 1992
Ophthalmology in Developing Countrie San Francisco. Contact University of Ca fornia at San Francisco, Extended Progran in Medical Education, Rm Ls-105, Sa Francisco, CA, 94143-0742 (415) 476-42

Mar 13–15, 1992
Cullen Eye Course: Clinical Advances i Ophthalmology. Houston. Contact Bayl College of Medicine, Office of CME, Or Baylor Plaza, Houston, TX 77030 (71 798-6020

Orthopedic Surgery

Mar 11–15, 1992
Orthopaedic Pathology Workshop. Dalla Contact The University of Texas Soutl western Medical Center, Office of CM

3 Harry Hines Blvd, Dallas, TX 75235
4) 688-2166

r 20–21, 1992
ances in Orthopaedic Surgery. Dallas.
ntact St Paul Medical Center, Office of
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sical Medicine and Rehabilitation

r 9–19, 1992
iew Course in PM&R. Houston. Baylor
lege of Medicine, Office of CME, One Bay-
Plaza, Houston, TX 77030 (713) 798-6020

stic Surgery

ar 7–8, 1992
inoplasty Symposium: An Anatomical
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Calendar of Meetings

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Jan 30–Feb 2, 1992, Fort Worth
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February

Feb 29, 1992, Austin
•Texas Medical Association Winter Leadership Conference
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March

Mar 4–6, 1992, Houston
•*Texas Association of Obstetricians & Gynecologists Annual Meeting*
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April

Apr 2–4, 1992, San Antonio
•*Texas Urological Society Annual Meeting*
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Apr 2–5, 1992, Houston
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- Find out the inside story about health-care reform measures being considered on Capitol Hill from **U.S. Sen. Lloyd Bentsen,** D-Texas.
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Letters

Satanic cult article draws criticism

I AM DISTURBED WITH YOUR editors allowing the publication of "High-risk adolescents and satanic cults" (*Texas Medicine*, October 1991, pp 74–76).

It asserts that (1) adolescents are attracted to satanic cults, (2) satanic cults follow a system of beliefs that proclaim an allegiance to the devil, and (3) specific rituals are used to channel power from Satan to the followers.

Outrageous claims made by alleged victims of satanists are simply accepted by the police, psychologists, and reporters. Apparently critical thinking goes out the window when the Prince of Darkness appears.

Recent issues of the *Journal of the Committee for Scientific Investigation of Claims of the Paranormal* and Robert Hicks' *In Pursuit of Satan and the Occult* (Prometheus Books) should convince anyone that these claims are false.

It seems only those who have a vested interest in believing them give any credence to them.

I hope your critical and scientific standards are reviewed so as not to publish such trash in a respected scientific journal.

Francis E. McIntyre, MD
2301 North Loop,
Austin, TX 78756.

RATHER THAN SHOWING the professional responsibility its author counsels, "High-risk adolescents and satanic cults" tends to fuel the fires of hysteria concerning "satanism."

The author assumes, without benefit of credible evidence, the pervasive existence of "highly organized" satanic cults that make use of "recruiters" and "believe in satanism as a highly orthodox religion." In fact, when his earlier version of this article appeared in the *Tarrant County Physician*, he admitted that he based it on the uncorroborated reports of disturbed individuals (personal communication).

Curiously, one of the author's own sources concedes that "scientific literature on satanism is scarce," that the organized "Church of Satan is more ideological than religious," and that the group activities described by their eight patients were "usually small, consisting of a few individuals," not even reaching "the sensationalistic extent of such groups as that dominated by Charles Manson" (1).

Another source for the author's positive assertions (2), (the pages given in his footnote are in error) also lacks hard data. Its authors are medical laymen so credulous that they even claim to have observed "raising of objects into the air, presumably through supernatural powers."

Still, there is agreement that these disturbed adolescents "tend to be loners" (2) and are alienated from peers as well as family and society (1). So why should their claims be accepted as fact? It seems more reasonable to see their bizarre behavior and lurid accounts as attempts to gain power by shocking and manipulating their listeners. This is especially so considering the negative results of careful investigation (3–5).

Most disturbing of all are that the author's "stages of involvement in activities of satanic cults" are completely without evidential support, as are the claims that "the concept of a higher power" and "the structure and discipline that a church can offer" are important in treatment. Just what does he think he's treating? Actual allegiance to and empowerment by an objectively demonstrable diabolical supernatural power? And just exactly what church is the author thinking can come to the rescue? Whatever else it is, this isn't medicine.

It's regrettable that the author hasn't bothered to read "the satanic bible" that he refers to as one of the "warning signs." If he had, he would know that LaVey's entertaining work (6) is not simply a printed version of heavy metal music. In fact, it specifically denounces "satanic" rituals such as blood sacrifices. Maybe the "numerous adolescents" that the author alleges are involved in satanism should read it!

Timothy N. Gorski, MD
2705 Hospital Blvd, Suite 107,
Grand Prairie, TX 75051.

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"HIGH-RISK ADOLESCENTS and satanic cults" made many references to heavy metal music's influence on certain teenagers and its involvement with satanism. I wish to pro-

vide another viewpoint regarding this musical form.

Much heavy metal music does not deal with occult or antisocial behavior. Quite the contrary, many bands use this high-energy form of music for social commentary. Granted, most of you do not understand this style, and I dare say very few have actually listened with an open ear, but it would be a disservice to your adolescent and young adult patients to dismiss it as satanic "noise."

Bands such as Metallica perform anti-cocaine songs ("Master of Puppets") and anti-war songs ("One," a song that all physicians should listen to and try to empathize with the central character to better understand some of their ventilator-dependent patients).

Queensryche performs songs like "Best I Can," which deals with a boy confined to a wheelchair who has decided to do as much as he can with the abilities he has. This could be the theme song for many rehabilitation units in the world.

The song entitled "Indians" by the group Anthrax deals with the plight of the American Indian. They also perform songs based on the literary works of Stephen King and others.

While I do not expect all readers to listen to heavy metal music, nor understand its musical keys, rhythmic patterns, and tempos, I do hope to expose them to another viewpoint. With Halloween approaching (as of this writing), the people who stage the annual witch hunts will doubtlessly spend much time trying to convince us that all heavy metal music is evil. But let us not forget that it wasn't long ago that Elvis was sinful and the Beatles were considered anti-Christs. A few years from now, we may be hearing Muzak versions of heavy metal songs in elevators!

I would like to see a study on the effects of country and western music's messages about beer drinking, cheating, wife abusing, etc, on young people, but none of us seem to be interested in the ill effects of this "art" form.

Terry Rolan, MD
3309 88th St,
Lubbock, TX 79423.

IN RESPONSE

I APPRECIATE THE INTEREST IN my article and the constructive criticism.

My article was based on my experience with hundreds of adolescents treated in the last 6 to 7 years, during which I have listened to most of the popular songs. My article was not meant to be totally critical of a particular kind of music but of the effects certain heavy metal groups can have on "vulnerable adolescents." Fortunately, all heavy metal music does not deal with occult or antisocial behavior, and a great majority of teenagers are not negatively affected by it. Some adolescent attire and behavior — long hair, leather jackets, earrings worn by boys, bedroom walls covered by grotesque heavy metal posters — can be a manifestation of normal teenage development, which includes testing limits by displaying certain degrees of defiance and individualism.

Unfortunately, some heavy metal music stars are role models for troubled high-risk youth. These performers deliver messages the adolescents want to hear: defiance of parents, society, traditional morality and ethics, free sexual indulgence, and satanic guidance. The lyrics emphasize freedom to do anything, to achieve instant gratification through drugs, sex, power, and violence. Although some musicians communicate positive messages, a large number of heavy metal musicians convey negative messages. Two examples of the hundreds of lyrics that glorify rape, sadomasochism, violence, and suicide are:

Guns & Roses "Anything Goes"
Panties around your knees
With your ass in debris
doin that grind with push and squeeze
tied up, tied down, up against the wall
be my rubber-maid baby
— we can do it all.

Venom "Sacrifice"
Candles glowing altar burning
Virgin's death is needed there
Sacrifice to Lucifer my master
Bring the chalice, raise the knife
welcome to my sacrifice
Plunge the dagger in the breast
I insist SACRIFICE
Demons rejoice Sacrifice

Whether or not these bands are serious, the image they project can have serious impact on young minds.

As I concluded in my article, not every adolescent with long hair who experiments with drugs and listens to heavy metal music is engaging in satanic cults; however, some adolescents who come from dysfunctional families and have underlying psychiatric problems *are* vulnerable to ritualistic antisocial behavior. Experience shows that the heavy metal music themes of casual sex, violence, drugs, and satanic messages *can* have a detrimental effect.

In my article, I shared my experiences with a number of adolescents who became preoccupied with satanic, ritualistic behavior and sought psychiatric help. My purpose was not to create sensationalism but to describe in detail the symptomatolo-

gy and behavior patterns. Irrespective of one's belief, we must have an understanding of the psychopathology, psychodynamics, and various influencing factors. I emphasize the need to recognize this behavior as symptomatic of underlying psychiatric illness.

M. Basheer Ahmed, MD
1015 S Henderson,
Fort Worth, TX 76104.

All physicians treat themselves and families, don't they?

DR PINKENBURG'S OFFHAND and slightly patronizing response to Dr Pohl's very reasonable letter (*Texas Medicine*, November 1991, p 6) deserves further comment.

[Dr Pohl's letter stated that the Texas Medical Association Insurance Trust denied his claim for an HIV-I test he ordered for himself. Dr Pinkenburg's letter stated that TMAIT's policy of not covering services ordered by an insured physician for himself or herself and for other family members conformed to the code of ethics of the medical profession that physicians not treat themselves or members of their families.]

Who decided that it is unethical for physicians to treat themselves, and by what authority? Should I consult an internist before taking an aspirin for a headache? Shall I send my wife and child to sit in a pediatrician's office because I can see an obvious otitis media? This is the level of Dr Pinkenburg's response to Dr Pohl who ordered an HIV test on himself.

Let's go further. Several years ago, with appropriate equipment and an experienced nurse, I attended my wife while she delivered our child at home. I dispute the right of any person to decide that this was unethical behavior. I believe that within my area of expertise, I can provide better medical care to my family than anyone else, partly because I know them so well. Isn't that what family care is all about?

Is there a physician in the country who has never treated himself or his family?

If an insurance company refuses to pay for these services, that is an entirely different matter. But unethical? Step down out of the clouds, Dr Pinkenburg.

Edward W. Dow, MD
Cornerstone Medical Center,
14711 Pebble Bend,
Houston, TX 77068.

IN RESPONSE

DR DOW'S LETTER TOUCHES on several issues that deserve further examination by all physicians.

My letter in response to Dr Pohl's letter should have contained language more appropriate than the "code of ethics" and it was certainly not meant to imply that a physician should consult another physician before "taking an aspirin for a headache." My comments were based on the opinion provided by the Texas Medical Association Board of Councilors.

The opinion, in fact, states:

> The Board of Councilors disapproves of a physician treating his or her own family, either medically or surgically, except for emergency situations, because of the many potentially hazardous medical consequences.

These "hazardous medical consequences" include lack of objectivity and potential for abuse. In addition, there exists the potential for abuse of the insurance system. I'm not aware of a major insurance company that will reimburse for a physician's self-treatment or treatment provided to a family member.

The self-treatment issue is expected to be on the agenda of the next Board of Councilor's meeting on February 28, 1992. I would encourage all physicians who would like to express an opinion to write the Board of Councilors prior to the meeting.

Ronald J. Pinkenburg, MD
Chairman, Board of Trustees
Texas Medical Association Insurance Trust
PO Box 1707,
Austin, TX 78767-1707.

[Editor's note: Write the Board of Councilors in care of Texas Medical Association, 401 W 15th St, Austin, TX 78701.]

Let's put a stop to emergency room abuse

DURING THE LAST 6 YEARS, I have been in private practice in rural Texas. It has had its good and bad moments. I have been able to incorporate obstetrics, pediatrics, surgery, gynecology, and medicine into my practice. However, being in the country, I also must take emergency room call with the other physicians at our hospital.

The emergency room is my least favorite part of practice. It seems to me it is one of the main reasons many physicians are leaving the country for the city. Every night when I am on call, I seem to be called to the hospital from about 9 pm until about 2 or 3 the next morning. Most of these calls are

non-emergency and the majority of the non-emergency calls are patients who are covered by Medicaid.

I want to propose a plan that will eliminate the majority of these calls and will make life in the country much more bearable.

I believe all Medicaid patients should pay a $25 payment when they use the emergency room for non-emergency conditions. However, because these patients usually are without cash, the payment should be taken out of their next public assistance check. The logistics would include:

1. The emergency physician will determine if the emergency room visit is an emergency. If it is an emergency, an emergency code will be selected and no payment will be withheld from the patient's check.
2. If the visit is determined not to be an emergency, a non-emergency code will be selected. The recipient's next check will be reduced by $25.

Right now, we as physicians are letting the government, insurance companies, and nonpaying or underpaying patients dictate how we live our lives and practice medicine. Unless we make a stand, it will continue to get worse.

Ralph Wehmer, MD
105 Loop 150 West, Suite G,
Bastrop, TX 78602.

Attorney charges "campaign of lies and deceit"

I READ WITH INTEREST THE results of the polling conducted by the Texas Medical Association concerning the public's perception of the cause of high medical costs (*Texas Medicine*, September 1991, p 21). The finding that 75% of the respondents in the Shipley poll blamed high malpractice insurance premiums paid by doctors, and 44% of the respondents in the Eppstein poll blamed high health care costs on lawyers and lawsuits, indicates that your campaign to convince the public that lawyers' rather than doctors' greed is the cause of high health-care costs has been successful.

Prior to my experiences in trial practice, I had been of the impression that a professional, including a physician, was a person of integrity who deals in truth rather than lies. Your campaign to divert blame is a campaign of lies and deceit. You know that malpractice premiums are a minor percentage of the gross income of doctors and hospitals, and consequently are not a significant factor in cost increases. If your response is that the costs are attributable to the practice of "defensive medicine," then please explain why patients should pay for procedures conducted for the benefit of the physician.

In the recent past, one of my clients was charged $1,200 per hour for a deposition by his treating physician. When I asked the physician the reason for that charge, he said that is what he earns treating patients. On an annual basis, then, his gross fees exceed $2,500,000. Incidently, I think for the skill he demonstrated, his fees are a bargain. Additionally, one of our local hospitals is moving from the state of Arkansas where it has charitable immunity to the state of Texas where apparently, despite the so-called medical malpractice crisis, it will be more profitable.

While certainly I do not disagree that a physician should charge whatever the market will bear, a person of integrity would not support a campaign of distortion and lies such as that which TMA has sold to the Texas public. If a physician's services are truly worth the fees charged, why not be proud rather than ashamed?

E. Ben Franks
Franks & Grimes,
PO Box 2710,
Texarkana, TX 75504.

IN RESPONSE

AS AN ATTORNEY, IT IS understandable that E. Ben Franks would be upset with recent TMA research that shows 75% of Texans believe high professional liability premiums paid by physicians is a cause of high medical costs and that 44% think high costs are the fault of lawyers and lawsuits. But what is not understandable is that, despite this and other research, Mr Franks suggests "professional liability premiums are not a significant factor in cost increases."

According to the AMA, professional liability premiums were the fastest growing component of physicians' practice costs during the 1980s. They jumped an annual rate of 15% between 1982 and 1989. Some specialties experienced an even higher increase. The average premium paid by obstetrician-gynecologists increased 71% between 1984 and 1989.

TMA's recent survey of physicians on indigent care shows that 15% to 40% of a patient's medical bill is attributable to "defensive medicine." And to not include these services as part of the patient's bill,

s Mr Franks suggests, would be lishonest and a misrepresentation.

The fact is, doctors are not ashamed" of their fees, as Mr ranks states. Rather, Texas Medical ssociation has, over the years, tried o educate the public about the nature of those costs and how liability laims, premiums, and other factors uch as utilization and technology, ll contribute to the costs we experience for our health care. The problem, according to Mr Franks, is that ve've been successful.

Susan Rudd Wynn, MD
Chairman, TMA Council on Communication
5929 Lovell Ave,
Fort Worth, TX 76107.

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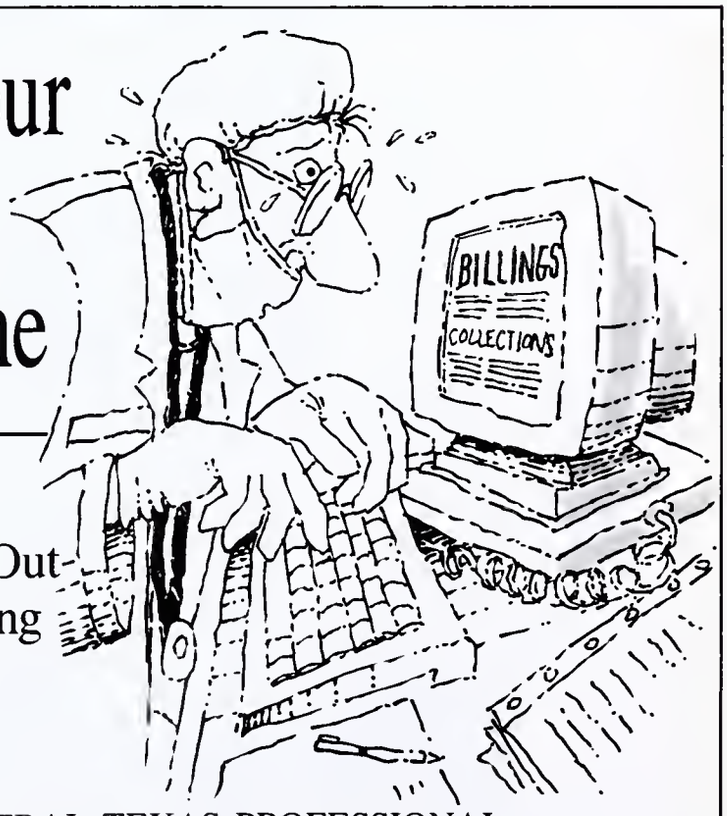

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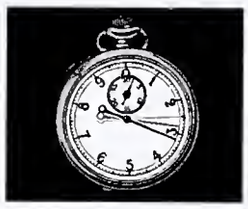

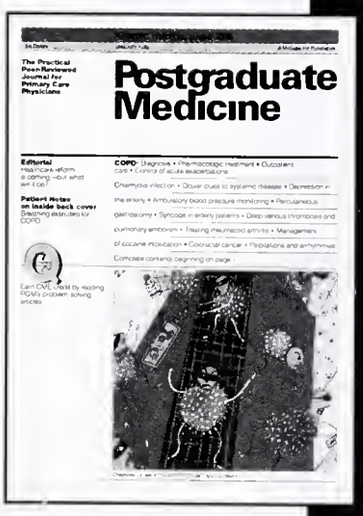

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CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Allergic-Type Reactions: VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
YDROCODONE		X			X
XYCODONE	XX	XX	XX	XX	XX

nk space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 91 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* '5; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. ern. Med.* 1980 588-96.

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1. Data on file, Knoll Pharmaceuticals
2. Standard industry new prescription audit

Please see brief summary of prescribing information on adjacent page.

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Upfront

Government and medical experts headline TMA leadership conference

EXPERTS FROM INSIDE AND outside the medical profession will share their knowledge with participants at TMA's 1992 Winter Leadership Conference, Saturday, February 29, at the Stouffer Austin Hotel.

US Sen Lloyd Bentsen (D-Tex), chairman of the Senate Finance Committee, will present a congressional view of health-care reform. Daniel H. Johnson, Jr, MD, Metairie, La, speaker of the American Medical Association's House of Delegates, will talk about the importance of "putting the patient in the driver's seat." Betty Jane Anderson, JD, Chicago, special counsel in the AMA's office of the general counsel, will deliver the Philip R. Overton Annual Lectureship in Medicine and the Law. She will discuss some of the legal challenges to physicians' practice and the medical profession.

A panel session, "Rising costs: is managed care the answer?" will be moderated by Jim Bob Brame, MD, Eldorado, past president of TMA. Panelists will include John A. Deane, executive director of UT-MED in Galveston, and John A. Davis, Dallas, principal and health and welfare practice leader, Foster Higgins.

James H. "Red" Duke, Jr, MD, director of trauma and EMS and medical director of LifeFlight, Hermann Hospital, Houston, has been invited to speak during the complimentary conference luncheon, underwritten by Texas Medical Association Insurance Trust. Dr Duke is spokesman for The University of Texas Health Science Center at Houston's "Texas Health Report."

Sue Rudd Wynn, MD, Fort Worth, chair of the TMA Council on Communication, will moderate a pre-conference "dawn duster" on "Health care reform: an analysis of public opinion and public perspectives" with panelists Patricia Clark, director of the department of issues management at the AMA, and Bob Lanier, MD, Fort Worth, creator/spokesman, "60-Second Housecall," KXAS-TV.

Three concurrent sessions complete the conference program. "CPR: Coping with payment reform" will be moderated by Frederick L. Merian, MD, Yoakum, chairman of the TMA Council on Socioeconomics. Featured on the panel is Barbara Harvey, director of staff services at Blue Cross and Blue Shield of Texas, Inc.

James L. May, a rural health clinic consultant in Richland, Mo, will present the concurrent session, "Exploring the Rural Health Clinic Services Act."

The third afternoon session, "Being a more effective spokesperson for medicine," features Patricia Clark and Lisa Stark Walsh, director, TMA public relations department.

The general conference runs from 9:30 am to 5 pm, with the "dawn duster" session scheduled for 7:45 am.

There is no registration fee for TMA members and association guests. Preregistration is suggested but not required. For further information, contact Jon R. Hornaday, TMA Special Services, (800) 880-1300 or (512) 370-1346.

Senator Lloyd Bentsen

Daniel H. Johnson, Jr, MD

Betty Jane Anderson, JD

A gathering of strength

ELEVEN TEXAS MEDICAL Association past presidents gathered in Austin November 15, 1991, for a meeting of the Past Presidents' Council. The group, which includes the 27 living past presidents of the association, convenes twice a year in conjunction with meetings of the TMA House of Delegates.

From the left, they are Howard R. Dudgeon, Jr, MD, Waco (1967-1968); Val F. Borum, MD, Fort Worth (1988-1989); Milton V. Davis, MD, Kaufman (1983-1984); Franklin W. Yeager, MD, Lindale (1959-1960); D. Clifford Burross, MD, Wichita Falls, (1985-1986); Charles B. Dryden, MD, Wichita Falls (1973-1974); Max C. Butler, MD, Houston (1989-1990); Ruth M. Bain, MD, Austin (1982-1983); Wm Gordon McGee, MD, El Paso (1990-1991); George G. Alexander, MD, Houston (1984-1985); and John M. Smith, Jr, MD, San Antonio (1977-1978).

These 11 physicians represent more than 450 years of service to the association.

A Legacy of Caring campaign draws wide support

HUNDREDS OF PHYSICIANS statewide have responded to the challenge of building "A Legacy of Caring" endowment fund. By year end, $3,531,365 had been raised for the TMA Education and Research Foundation's endowment, and campaign managers were still tabulating returns from a November appeal to Texas physicians.

"Our initial success speaks loudly for the physicians of Texas," says Max C. Butler, MD, Houston, chair of the state steering committee. "We hope all TMA members will contribute toward this new endowment, which will demonstrate to the public that physicians are sincere in their efforts to improve the health of Texans and the quality of Texas health care."

The endowment will support public health and medical information and education programs that have the highest opportunity for improving the health of Texans.

TOLL-FREE ACCESS TO TMA

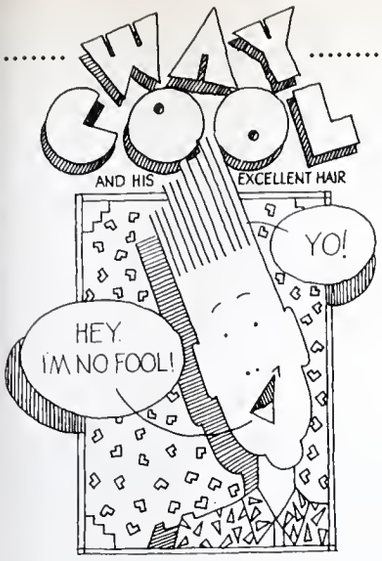
THE NEW TOLL-FREE NUMBER for TMA members to use in calling all TMA departments is (800) 880-1300. If you get a busy signal you may wish to dial TMA's main number, (512) 370-1300, to reach the switchboard. Or the direct-to-desk phone lines of individual staff members can be used.

Donors who give at four levels will receive recognition by having their names displayed prominently on the donor wall in the new TMA building in Austin: Benefactor $50,000 or more; Patron, $20,000 to $49,999; Honor Roll, $5,000 to $19,999; and Friend, $1,000 to $4,999. In addition, donors who pledge $5,000 or more by April 1, 1992, will receive special recognition as "founders" of the endowment fund.

To support the fund, contact the TMA Resource Development Department, 401 W 15th St, Austin, TX 78701, phone (800) 880-1300 or (512) 370-1370.

Physician support vital for adolescent health project

A LIVELY LOOKING CARTOON character, "Way Cool," needs your help in reaching Texas adolescents. As the spokesman for the Texas Medical Association Auxiliary's adolescent health project, his job is to promote healthy attitudes towards life, such as staying in school and staying away from trouble.



The campaign was designed by the uxiliary's Adolescent Health Comittee, chaired by Melanie Lockhart, ustin, in response to studies indicatng that five factors are primarily reponsible for the 11% increase in norbidity and mortality rates for dolescents in the past 20 years:

- substance abuse;
- sexuality and pregnancy;
- victimization;
- psychological disorders and suicide; and
- violence and trauma.

Activities in the 1992 TMAA proect center around April 1, which has een designated Adolescent Health Day, with the theme, "Don't fool around with your health." Among the activities planned are:

- Book covers featuring "Way Cool" advocating healthy lifestyles. The book covers also list Texas hotline numbers covering drug and alcohol abuse, smoking and tobacco abuse, child and family crises, and AIDS and STDs. The goal is to provide book covers for every sixth, seventh, and eighth grader in Texas.
- Public service announcements for radio and television.
- "Ask the Doc" phone lines. Exclusively for teens, the phone lines will use local physicians in cooperation with television stations, timed during after-school hours on April 1.

Physicians are urged to help with the project by contacting their local auxiliary president. Further information is available from Kitty McMinn Kress, TMAA program director, 401 W 15th St, Austin, TX 78701, phone (800) 880-1300 or (512) 370-1328.

1992 Annual Session planned May 14-17 on San Antonio Riverwalk

THE 1990S HAVE BROUGHT a host of new challenges for Texas physicians to meet, and TMA's 125th Annual Session, to be held in San Antonio May 14–17, will get down to basics on the issues of Medicare payments, safe harbor rules, hassle factors, and more.

The 1992 session, planned for San Antonio's beautiful and historic Riverwalk, will have an emphasis on issues affecting primary care physicians, according to Dale Willimack, TMA director of annual session and meeting management.

"The Council on Annual Session and Scientific Programming feels that in every specialty, there are portions of that field that relate to primary care," she said. "We are going to pull out topics from all the specialties that pertain to primary care: family practice, ob/gyn, internal medicine, pediatrics, and general surgery.

"We are trying to be a little more practical," she said. "We hope that what they learn during the sessions can be used in their offices or hospitals the next week."

There will be more than 350 scientific, socioeconomic, medical, and legal presentations during the 4-day session, with more than 40 scientific programs in every specialty. On Saturday, May 16, general sessions in a "town hall" format will be presented. Topics to be explored in the general sessions include the public image of the physician, an overview of the new Medicare payment system, and methods of understanding and improving third-party reimbursement.

There also will be some 225 CME credit hours of programming.

The House of Delegates sessions, reference committees, scientific programs, and exhibits will be staged at the San Antonio Convention Center. Headquarters hotels for the sessions will be Marriott Riverwalk, the Marriott Rivercenter, the Hilton Palacio del Rio, and the Hyatt Regency.

Several major social events are planned during the session. On Thursday, May 14, from 5-6:30 pm, a Welcome Fiesta is scheduled on the Convention Center River Court with time for camaraderie, food, music, and drink. On Friday, members and guests will enjoy the Niosita Festival (A Night in Old San Antonio) at La Villita, from 6:30-11 pm.

There is no registration fee for TMA members.

For more information, see the four-page Annual Session insert beginning on page 59 of this issue. This insert contains the last registration form to be printed in *Texas Medicine* before the session.

Correction

THE NAME OF THE FOURTH COAUTHOR of "The Ilizarov technique in the treatment of osteomyelitis," was inadvertently omitted from that article in the December issue of *Texas Medicine*. Billy R. Ledbetter, third-year medical student at The University of Texas Medical Branch at Galveston, should have been listed along with Jason H. Calhoun, MD; Diane M. Anger; and Jon Mader, MD.

Thank you, Doctor

By Carol Gray Weathers*

MY JOB AS A VETERAN VIDEO specialist and producer for Texas Tech University Health Sciences Center in Lubbock has taken me into operating rooms where I've videotaped magnificent technical exploits. In shiny offices and humble rural clinics, physicians' labors have been the target for my camera. At hospital bedsides I have recorded green residents and seasoned specialists. And when I have it all on tape, I translate their academic, research, and practical achievements into the language of the lay public.

But recent events forced me from my role as "spectator" to that of "participant." By sharing my experience, I hope to show what a vital difference physicians can make in the way patients and their families deal with impending death.

Having videotaped many labor and deliveries, I was looking forward to taping the birth of my daughter Luann's first child. Even though sonograms had hinted at possible problems, we were greatly anticipating the event. Luann had already picked the name "Heidi" for her new baby.

Luann's labor was not particularly extraordinary. I focused on Heidi's arrival in my camera viewfinder. Although she seemed alert, she wasn't crying and she didn't move much. I was enchanted, taking "grandmother-type" video when I noticed the concern of the nurse. Heidi was more than just "relaxed." After a whispered consultation with the doctor, the nurse admitted Heidi to the neonatal intensive care unit.

In the unit, it was determined that Heidi had some kind of infection, but no one really defined it. There were blood cultures and other tests. We were concerned, but the second-year resident who was Heidi's physician was a young man I had worked with previously. He was not only extremely competent, but he seemed really to care about his patients and their families. I thought of the stereotype of the old family doctor, beloved and trusted by generations. Heidi's doctor fit the image.

Antibiotics and oxygen and competent care strengthened Heidi enough to come home and enjoy her first Christmas with her family. As alert as ever, she seemed very gentle and calm with a "lady-like" quality about her. Her tiny hands fluttered slightly, like delicate little butterflies. Other than that and her extremely active little face, she didn't move much.

Well-meaning friends advised that some babies develop more slowly. When we took her for her 1-month checkup, the doctor looked at her very thoughtfully. He was reassuring as he noted our concerns, and suggested we continue to watch her.

EARLY MORNINGS WERE wonderful. Heidi didn't really cry — just let Luann know she was awake and ready to eat. Then the rest of us took turns tickling her, blowing her tummy to make her laugh, and holding her. The whole household began to revolve around Heidi, and Luann planned to stay home with her for 6 weeks before returning to work as a nurse.

Holding Heidi was a special joy. Although she still wasn't holding up her own head as December became January, she seemed to hug you in a soft embrace as she burrowed her little head into your shoulder. Then, on one of those early January mor ings, while we were taking turn cuddling her, Heidi turned ashe blue and lifeless.

When we arrived at the hospita emergency room, they were read Quickly they stripped her little paja mas off and attached all kinds o leads and lines while someone applie oxygen. Her little naked body wa such a cold, mottled blue color. A this point I was too numbed to b scared. Luann seemed anxious, bu strong. The head pediatrics residen explained something called respirato ry syncytial virus, and soon we wer up in the pediatric intensive care unit.

As Heidi's regular physicia joined the other doctors, we relaxe a little. Batteries of tests were run . . x-rays, EEGs, blood tests. After a couple of days, two of the residents began urging my son, who was a fourth-year medical student, to rea in his pediatrics textbook abou floppy child syndrome. He and I went home and searched the long paragraphs.

He was quiet and didn't explain the technical medical terminology, but I knew what it said. It said Heidi was going to die.

We went back to the hospital and tried to prepare my husband as best we could. At first he didn't believe us. Then he just wept. We all agreed we should wait for all the test results to come back for a definitive diagnosis before telling Luann.

And then the doctor was there, explaining some kind of skeletal muscular atrophy called Werdnig-Hoffman. It didn't matter what the disease was called. It was terminal.

Looking down at that darling little baby who smiled up at us so sweetly, it hurt horribly to think we would not get to keep her. I've read that in such situations one often feels

Special thanks to Douglas Klepper, MD

nger. I felt only supreme sadness.

Heidi's room was dark a lot, I remember that. The way we felt was darker. Confused. Scared. How do you do it — have a baby die? We were totally lost.

One specialist, upon informing us of the final diagnosis, told us that since the baby was terminal we didn't need to see him anymore. Chop! Just like that! It felt like one of the few lines to reality had been severed.

There was only one doctor left — Heidi's physician. He was young, but he seemed old beyond his years. He saw the pain we were feeling, but instead of distancing himself from a situation that held only the promise of loss and pain, he literally stepped into our family. In his compassion, he allowed himself to be touched by our pain as he held out his hand to steady us. We did not know how to let someone die with love and peace and dignity. He did.

Only 1 year earlier, he had watched his own sister go through exactly what Luann was experiencing when his nephew was born and died with Werdnig-Hoffman. He knew the great pits of hopelessness. But instead of drawing back from us, he reexperienced some of his own family's pain in order to help us.

WHEN WE FINALLY TOOK Heidi home from the hospital, it was with bittersweetness. After much discussion with Heidi's doctor, we determined we would treat Heidi as much like a "normal" baby as possible — no mourning! There would be (and has been) time enough to cry when she was gone. While she was with us, we celebrated. Heidi's doctor was equally determined to help us make the most of Heidi's life, however long that might be.

When she started babbling and cooing, we recorded her laughter. I took every opportunity to videotape her, and everyone in our family noted we took more pictures of Heidi in her short lifetime than we had of all three of our grown children. And of course, there was no further talk of Luann going back to work.

When it was time for regular "well-baby" checkups, Heidi's doctor was always upbeat. We would point out the milestones, and he would let us babble on in optimism. He never "rained on our parade," allowing us to vocalize our hopes, but when we would ask him about possibilities, he was always gently frank with us.

He knew what lay ahead, and he tried to prepare us as much as we would let him. When we overrode his experience, he would hug us all and smile kindly. He knew, and so did we. But he let us hope. I don't think we could have survived this without the hope.

As the days turned into weeks, and then into months, and Heidi seemed to be gaining strength, we really began to hope she would be a miracle. The movement in her hands seemed enhanced, and she even began moving her legs, especially in the bath. Her doctor listened quietly as we prattled on.

A BUSINESS TRIP REQUIRED ME to be out of town for 4 days. When I returned, Luann tried to prepare me before I saw Heidi. I was shocked. She had lost more than a whole pound in that short time. Her swallowing — just as the doctor had warned us — was becoming severely impaired. He had made arrangements for a nurse to teach Luann how to feed Heidi with a nasogastric tube.

In a few days Heidi regained her weight and most of her energy. Shaken, we began to talk about possible eventualities.

As a nurse, Luann knew the risks and problems of a patient on a ventilator. She felt that if Heidi was ever put on a respirator, she would never come off it. (In fact, when a muscle biopsy had been required earlier, she had pleaded with the anesthesiologist not to use a general anesthetic, which would have required the respirator.) She very sadly, but firmly, made the rest of us in the family promise if we were taking care of Heidi in a crisis, we would not allow her to be put on a respirator.

One day while I was at work, Luann went to the cemetery and made arrangements to buy a burial plot.

The days passed, and it began to seem our worries were wasted. Heidi seemed more energetic than ever. On Saturday of her first week being fed by tube, her uncle from Seattle showed up for a surprise visit. About 6 pm, she began running a low grade fever. By 8:45, it was climbing. By 9:15, she had a breathing crisis, and we rushed her to the emergency room.

This time her doctor, whom we had alerted, was there waiting for us. He was so gentle. He told Luann they needed to draw some of Heidi's blood, but she was quite upset. She didn't want anyone but the doctor to stick Heidi. Gently he drew the blood from that little forearm and held it tightly in his hand, his other arm around Luann as we waited for the lab results. It was quiet in that exam room. I remember only the soft whisper of oxygen as we all stared intently at Heidi, as if our intensity could strengthen her.

When the lab technician brought

the slip to him, the doctor read it silently. Luann questioned him.

He turned to her with the saddest look I have ever seen. "It is what we should expect to see with this, Luann."

"Is it a matter of weeks? Days?" Luann was pleading with him, almost bargaining.

"No, Luann. Hours." The words must have been very hard for him to say. They were impossible to hear.

LUANN ASKED IF WE COULD take Heidi home, and he nodded. He left us alone then, my husband, Luann, and I with Heidi, to make the arrangements for oxygen to be delivered at our home. All of a sudden, Luann gave Heidi to me and said she had to leave for a minute.

I had to hold that dear little baby in my arms while she looked up at me in absolute terror. It has been explained to me that she couldn't have been afraid, but she looked terror-stricken. Somehow I held her and whispered to her, to let her know how much we loved her, and we were there with her. My dear husband held us both, and then Luann was there, and we all held each other as each breath became more agonizing for Heidi.

I discovered later that Luann had stepped out to say a prayer and ask that Heidi be released from her suffering. As her life slipped away, Heidi's eyes rolled back and her body went limp. Then, her eyes opened normally and she looked right straight at us. The terror was gone. In its place was the sweetest expression of peace and even comfort. Then her little eyes closed shut gently.

Luann cried out for the doctor, and he was there. We were all crying, and I remember the tears in his eyes and in the nurse's eyes. How I loved them for caring.

He made the arrangements for us and let us be alone with Heidi to say goodbye.

FOR THE MOST PART, WE ARE getting on with our life. Luann is working at a nursing home, and except for when thoughts of Heidi interrupt her sleep, she seems all right. Sometimes she comforts my husband and me when the tears come.

For us, Heidi's doctor worked a miracle. It wasn't a miracle of curing. It couldn't have been. Medical science has not yet found the solu tion for the puzzle of Werdnig-Hof man. But it has been a miracle c caring. The joy and love we had fo that 4 months with our little Heidi i something we will always treasure And the fear and uncertainty o what lay before us was bearable be cause he walked with us every ste of the way.

As a physician, he gave us every thing that modern medicine coul give. As a human being, he gave o himself.

Thank you, doctor, for everything. ★

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7:00 Cassatt & Degas on Canvas
8:30 Schumann: Poetry, Passion, Prophecy

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NEWSMAKERS

The Texas Department of Mental Health and Mental Retardation has named **Spencer Bayles, MD,** recipient of its Mary Holdsworth Butt Award. A retired Houston psychiatrist, Dr Bayles is a member of the Texas Medical Association Council on Scientific Affairs and consultant to the TMA Committee on Mental Health and Mental Retardation.

Daniel A. Chester, MD, McAllen, has been elected vice chairman of the South Central District of the American College of Obstetricians and Gynecologists. A past president of the Texas Association of Obstetricians and Gynecologists, Dr Chester currently serves as vice chairman of the Texas Medical Liability Trust board of governors and medical director of the Hidalgo County Planned Parenthood Association.

Betsy S. Comstock, MD, director of community psychiatry at Baylor College of Medicine in Houston, has received an award of honor from the Mental Health Association of Houston and Harris County. Recipient of the association's 1991 Helen Farabee Community Leadership Award for her work in initiating and organizing Houston's mental health crisis team, Dr Comstock has worked with the Goose Creek Independent School District to coordinate the mental health response to a cluster of adolescent suicides.

Please let *Texas Medicine* know about your honors and achievements.

Criteria for inclusion in the Newsmakers section are: TMA member; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, Texas Medicine, *401 W 15th St, Austin, TX 78701.*

Wichita Falls physicians **Charles B. Dryden, MD,** and **William L. Rector, MD,** have received distinguished service awards from the Wichita County Medical Society for "outstanding service to humanity."

H.A. Tillmann Hein, MD

H.A. Tillmann Hein, MD, Dallas, has been elected president of the Dallas County Anesthesiology Society.

Joe Horn, MD, Plainview, has been elected president of the American Physicians Art Association (APAA). Elected to serve as secretary-treasurer of the association is **Ray Freeman, MD,** of Hale Center. Both physicians received awards for their artistic works at the 54th annual APAA art exhibit held in December.

Dennis J. Lynch, MD, chairman of the department of surgery at Scott and White Hospital in Temple, has been elected assistant secretary to the board of directors of the American Society of Plastic and Reconstructive Surgeons.

James Mobley, MD, a Portland physician and colonel in the Army Reserve, was awarded the Order of Military Medical Merit by the US Army for his service during Operation Desert Storm.

Paul E. Pepe, MD, received the Health Policy Leadership Award from the Houston Area Health Care Coalition. Dr Pepe, who has served as emergency medical services director for the city of Houston since 1983, was recognized for improving the medical care received by accident and heart attack victims.

Mario E. Ramirez, MD

Mario E. Ramirez, MD, a Rio Grande City family physician and past president of the Texas Medical Association, has received the University of Tennessee College of Medicine 1991 Outstanding Alumnus Award in recognition of extraordinary service to the school and to the medical profession.

Harlan J. Spjut, MD, Houston, has received the George T. Caldwell Award for Distinguished Service from the Texas Society of Pathologists. The annual award recognizes an outstanding medical scientist in Texas for his or her long and distinguished service to pathology. Dr Spjut is professor of pathology at Baylor College of Medicine.

CORRECTION

Cecil Alfred Robinson, MD, Kermit, was reported deceased in the January 1992 issue of *Texas Medicine*. Both Dr Robinson and his wife, **Lila Rose Robinson, MD,** are alive and well in Kermit. The editors of *Texas Medicine* deeply regret the error and extend best wishes for continued good health to the Drs Robinson.

OBITUARIES

Cenon Quipse Baltazar, MD, 67; Fort Worth; University of Santo Tomas, Philippines, 1951; died December 7, 1991.

Carl DeVaux Barker, MD, 84; Paris; University of Arkansas School of Medicine, 1935; died August 29, 1991.

Robbie Neeley Brunner, MD, 91; San Antonio; University of Colorado Medical School, 1928; died October 9, 1991.

Joseph W. Burke, Jr, DO, 61; Fort Worth; Chicago College of Osteopathic Medicine, 1957; died November 30, 1991.

Fred B. Cooper, MD, 90; Wetmore; University of Illinois Medical School, 1929; died September 1, 1991.

Joe Frank Hillhouse, MD, 64; Paris; Baylor College of Medicine, 1952; died July 22, 1991.

John H. Hooker, MD, 62; New Braunfels; University of Oklahoma School of Medicine, 1955; died July 30, 1991.

Charles Edwin Kime, MD, 72; Midland; Indiana University Medical School, 1942; died October 17, 1991.

James Thompson Lee, MD, 75; Wichita Falls; University of Pennsylvania School of Medicine, 1940; died November 1, 1991.

James Joseph Meaney, MD, 72; Corpus Christi; Marquette University School of Medicine, 1953; died November 23, 1991.

Carleton McKenzie Neil, MD, 75; Houston; Cornell University Medical College, 1942; died September 18, 1991.

William H. Newkirk, MD, 83; Alice; University of Iowa College of Medicine, 1933; reported deceased.

Philip M. Prieto, MD, 74; El Paso; The University of Texas Medical Branch at Galveston, 1942; died November 21, 1991.

Lester H. Quinn, MD, 94; Dallas; Indiana University School of Medicine, 1927; died November 13, 1991.

John R. Rainey, Jr, MD, 70; Austin; The University of Texas Medical Branch at Galveston, 1946; died November 29, 1991.

Ernest D. Rogers, MD, 91; Fort Worth; The University of Texas Medical Branch at Galveston, 1928; died November 28, 1991.

Robert Jarman Rowe, MD, 77; Athens; Baylor College of Medicine, 1936; reported deceased.

Ronald Smith, MD, 73; Fort Worth; University of Oklahoma School of Medicine, 1944; died November 4, 1991.

Theodore J. Taliaferro, MD, 81; Tyler; Meharry Medical College, 1937; died November 28, 1991.

Julian Alexander Wells, MD, 60; Dallas; The University of Texas Medical Branch at Galveston, 1956; died November 12, 1991.

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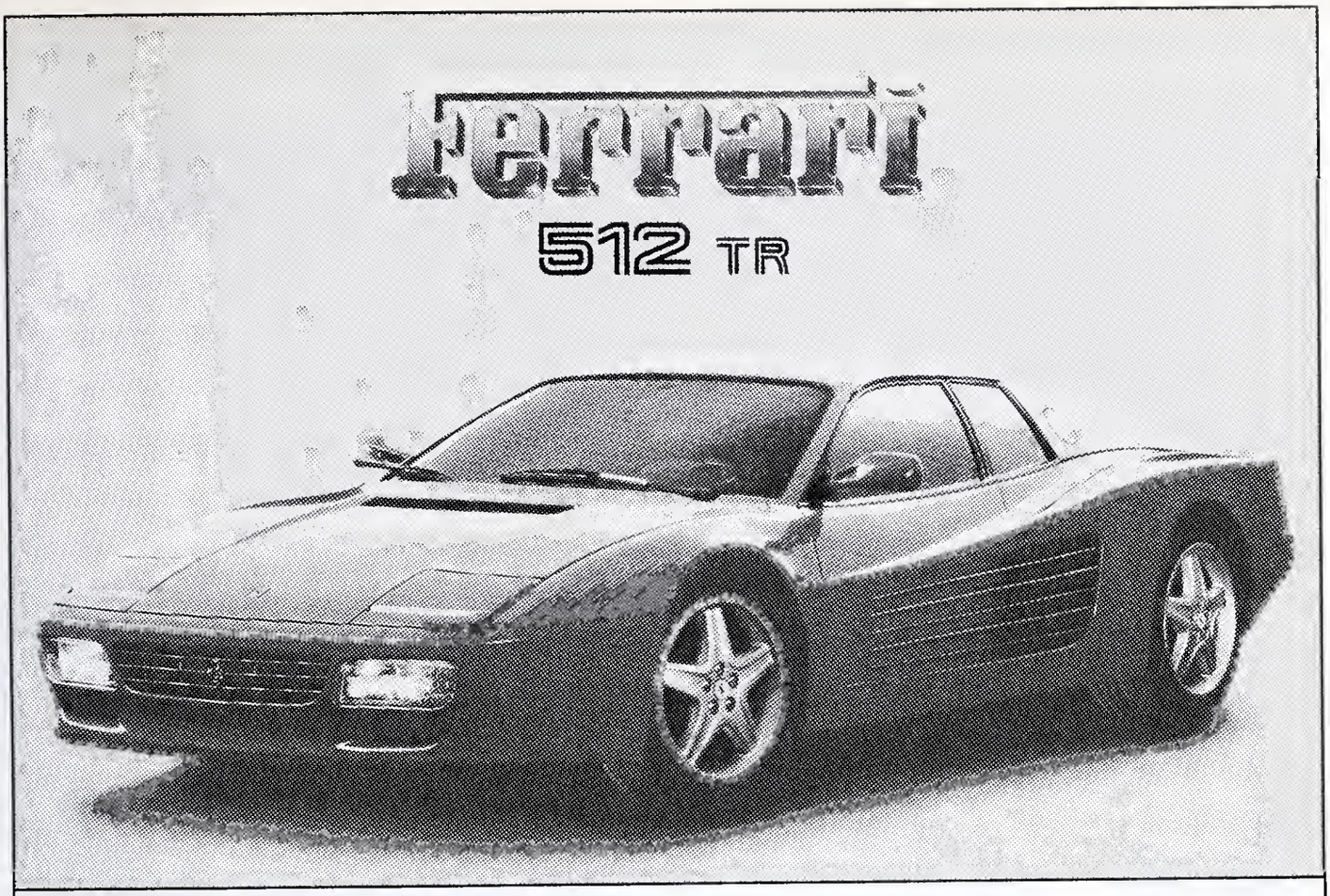

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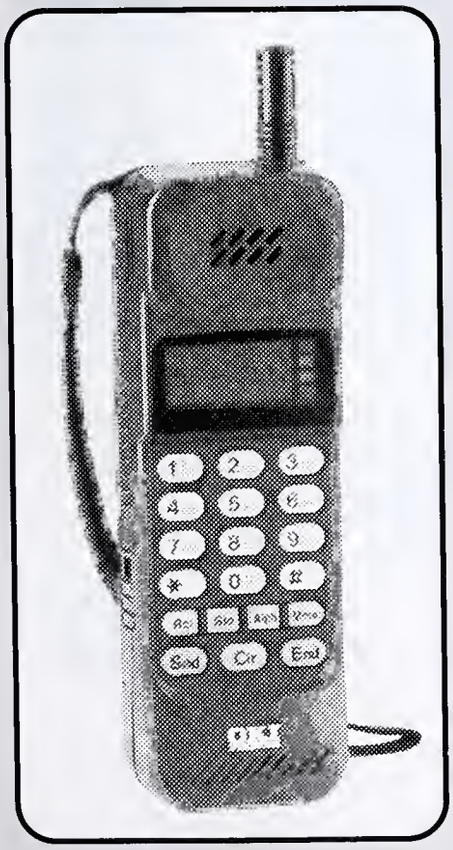

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Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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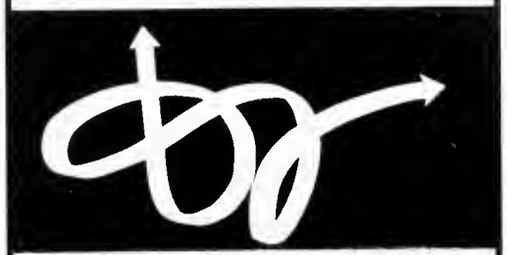

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Law

OSHA issues regs on bloodborne pathogens

ALL PHYSICIANS WILL BE required later this year to offer free, voluntary hepatitis B vaccinations to all employees who may come in contact with blood and other potentially infectious materials as a result of their jobs.

The vaccinations are one part of the long-awaited regulations establishing a bloodborne pathogens standard issued by the Occupational Safety and Health Administration (OSHA). The standard, designed to reduce exposure to all bloodborne pathogens, including the hepatitis B virus and the human immunodeficiency virus (HIV), applies to physician offices, hospitals, nursing homes, and other ambulatory health-care settings. Violation of the OSHA guidelines could result in a fine up to $70,000 per incident.

OSHA anticipates the Occupational Exposure to Bloodborne Pathogens' standard will protect more than 5.6 million workers and prevent more than 200 deaths and 9,200 bloodborne infections each year.

The requirements were published in the December 6, 1991, issue of the *Federal Register*. The rules become effective 90 days after publication (March 5, 1992), with subsequent deadlines for implementation of various parts of the rules. The provisions governing hepatitis B vaccinations take effect 120 days after March 5.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

The vaccinations are to be made available to employees within 10 working days of employment; at a reasonable time and place; under supervision of a licensed physician or health-care professional; and in accordance with the latest US Public Health Service (USPHS) recommendations. If an employee declines the vaccination, a refusal form must be signed. He or she may, however, request the vaccine at a later date. Booster doses must also be made available, if required by USPHS. Medical records must be kept on each employee and must remain on file during employment in addition to 30 years.

"The greatest bloodborne risk workers face is the threat of infection posed by hepatitis B virus."

"The standard mandates engineering controls, work practices, and personal protective equipment that, coupled with employee training, will reduce on-the-job risks for all employees exposed to blood," says Assistant Secretary of Labor Gerard F. Scannell. "Nevertheless, the greatest bloodborne risk workers face is the threat of infection posed by hepatitis B virus. OSHA estimates that occupational exposures account for roughly 5,900 to 7,400 cases of HBV infection each year," he says.

"It is vital that we protect workers who put their lives on the line to provide compassionate care for other Americans in illness and emergencies — protecting and saving lives, treating the sick, cleaning rooms, and discarding wastes — from the risks of contracting AIDS and hepatitis B as a result of workplace exposure," he says.

The standard:

- covers all employees who coul be "reasonably anticipated" as result of performing their job du ties to face contact with blood;
- requires employers to identify i writing tasks and procedures a well as job classifications wher occupational exposure to bloo occurs;
- mandates universal precautions;
- requires a written schedule o cleaning;
- instructs employers to provide, a no cost, and require employees t use appropriate personal protec tive equipment; and
- directs that an exposure contro plan must be completed withi 60 days of the effective date; in formation and training require ments must take effect 90 day following the effective date. To b enforced 120 days after the effec tive date are engineering an work practice controls, persona protective equipment, housekeep ing, special provisions covering HIV and HBV research laborato ries and production facilities hepatitis B vaccination and post exposure evaluation and follow up, labels and signs.

'ederal law spells out ights of the disabled to nedical care

ugh M. Barton, JD
'MA Assistant General Counsel

)n January 26, 1992, an important ›ortion of the Americans with Dis- bilities Act became effective. This ›ortion of the federal law prohibits liscrimination against disabled per- ons by private parties in places of ›ublic accommodation and requires hat all new places of public accom- nodation and commercial facilities ›e designed and constructed so as to ›e readily accessible to and usable ›y persons with disabilities.

Q: Is a physician's office a place of "public accommodation?"
A: Yes. The act specifically states hat the "professional office of a health-care provider" is a public ac- commodation.

Q: What is a "disability?"
A: The term "disabled" means: (1) having a physical or mental impairment that "substantially limits" one or more of a person's major life activities; (2) having a record of such an impairment; or (3) being regarded as having such an impairment.

Q: Who is considered "disabled" under this definition?
A: Persons with orthopedic, visual, speech, and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, traumatic brain injury, specific learning disabilities, HIV disease (symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism are specifically mentioned. However, "disabled" doesn't include homosexuality or bisexuality.

Q: What is prohibited?
A: In general, discrimination against persons who have these kinds of disabilities is prohibited. Four specific kinds of discrimination are prohibited:

1. imposition or application of eligibility criteria that keep a disabled person from fully and equally enjoying services offered unless necessary to provide the services;
2. failure to make reasonable modifications in policies and procedures necessary to provide services to disabled persons;
3. failure to provide auxiliary aids and services if necessary to comply with the law; and
4. failure to remove architectural barriers where removal is readily achievable.

Q: How do the "eligibility criteria" for use of services apply to physicians?
A: The final rules do not address the issue with respect to health care. However, an example of how it will be applied is seen in restaurants. The rules state that a restaurant may not "limit the seating of individuals with Down's syndrome to only particular areas" stating that "the wishes, tastes, or preferences of other customers may not be asserted to justify criteria that would exclude or segregate individuals with disabilities." Thus, it appears that physicians may not segregate or exclude the disabled from their offices simply because nondisabled patients object.

The rules suggest that physicians must accept HIV-infected patients who present with a condition they treat.

Q: Does the requirement that policies be modified to accommodate the disabled compromise specialization?
A: No. The law does not require modifications to legitimate areas of physician specialization. A physician may still refer a disabled person to another physician if that person seeks or requires treatment outside of the referring physician's area of specialization, and the referring physician would normally make a similar referral for a nondisabled person who seeks or requires the same treatment. Requiring a physician to accept patients outside of his or her specialty would fundamentally alter the nature of the medical practice and is not required.

Q: Are physicians required to accept HIV-infected patients under this law?
A: Traditionally, physicians need not accept all potential patients who have a condition they can treat. The rules use the example of a drug rehabilitation clinic. Such a clinic could refuse to treat a person who is not a drug addict, but could not refuse to treat a drug addict simply because the patient tests positive for HIV. The rules thus suggest that physicians must accept HIV-infected patients who present with a condition they treat. But it is not clear that they must accept *all* potential patients who have both conditions that are treatable within their scope of practice and HIV infection.

Q: When can a disabled patient be referred to another physician?
A: It is not the law's intent to prohibit physicians from referring dis-

abled patients to other physicians, if the disability itself creates specialized complications for the patient's health that the physician lacks the experience or knowledge to address. In other words, referral is permitted if the disability manifests complications requiring the expertise of a different physician.

Q: How do the architectural barrier requirements affect physicians' offices?

A: A physician's office, like other "public accommodations," must provide service to disabled persons in the most "integrated" setting. Thus, "segregated" seating for persons in wheelchairs would appear to be categorically prohibited. However, the law only requires removal of architectural barriers to the extent that removal is "readily achievable." Thus, if providing access to all areas of an office would not be "readily achievable," it may be permissible to provide access to selected areas only. Also, the law provides that, where barrier removal is not readily achievable, alternative and readily achievable methods of making services available are permissible.

Q: When do these requirements go into effect?

A: Existing buildings that are altered after January 26, 1992, must be altered so as to allow access and use by the disabled. Normal maintenance, redecorating, and electrical system changes are generally not considered alterations. All offices designed and constructed for use after January 26, 1993, must be designed to allow access and use by the disabled, unless it is "structurally impracticable."

Q: What about Seeing Eye dogs? Does a physician's office have to allow them?

A: Yes. The rules provide that "a public accommodation shall modify policies, practices, and procedures to permit the use of a service animal by an individual with a disability," meaning that a physician's office must allow a blind patient to bring a Seeing Eye dog into the office. They do not, however, have to supervise or care for such animals.

Q: What "auxiliary aids and services" must a physician's office provide?

A: This requirement has not been developed in the context of health care. In general, auxiliary aids and services include things that are necessary to make material available to people with visual and hearing impairments. This is a flexible requirement and does not require the use of the most advanced technology.

Q: What are the penalties associated with this?

A: There are a number of remedies. Civil actions for preventive relief may be brought by an aggrieved person. The US attorney general may investigate alleged violations and may bring civil action in federal district court. Monetary damages and civil penalties, not exceeding $50,000 for a first violation and $100,000 for any subsequent violation, may be awarded. There appears to be no administrative procedure available as under Medicare law.

Legal articles in Texas Medicine *are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.*

Insurance overpayment: retain or return?

C. Lee Parmley, MD, JD
Medical Legal Consultant, The Woodlands
Roger M. Baron, JD
Associate Professor, University of South Dakota, School of Law

PHYSICIANS MAY BE UNDE no obligation to return exces insurance benefits paid directl to them on behalf of their patients.

This is true in situations wher insurance funds have been paid fo services that were actually rendere by the provider, even though th payment is mistakenly made beyon policy limits. In order to legally re tain such funds, the overpayment must be the result of the insurer' mistake and not be induced by an wrongful act or omission of the ir sured or the doctor.

Disputes in which insurers see recovery of payments mistakenl made directly to their insureds ar not new to legal scholars. By con trast, disputes rising directly be tween insurers and doctors have much shorter history. A review o the legal principles and case law al lowing a doctor to retain overpai insurance benefits was published i the South Texas Law Review (1).

Restitution and exceptions

As a general rule, the law of restitu tion requires the recipient of monie or services to pay for the services o return the monies, if failure to do s would enrich him unjustly. In short the unjustly enriched recipient mus make restitution.

However, there are many excep tions to the general rule of restitu tion, two of which are most likely t apply to doctors. First, if fund owed to one party are mistakenl

paid to an innocent creditor of that party, there is no requirement that the funds mistakenly paid be returned. Second, where the recipient has materially changed his position upon receipt of the mistakenly paid funds, they need not be returned.

Case law denying recovery

The leading case is a 1974 Nebraska Supreme Court decision in which the court ruled in favor of the hospital in the dispute wherein an insurer sought recovery of funds it had overpaid directly to the hospital on behalf of its insured (2). In this case the hospital had secured from its patient, the insured, an assignment of insurance proceeds due under the policy.

Recognizing that traditionally the general rule of restitution would allow recovery of the overpayment, the court held that the general rule did not apply in this situation where payment was made to an innocent third party creditor of the insured. Also notable were the circumstances surrounding the incident; the overpayment was made solely due to the insurer's mistake, with no misrepresentation by the hospital, which had acted in good faith and without prior knowledge of the mistake. The hospital retained only the amount actually due for the services rendered.

A court of appeals in Houston followed Nebraska's lead in a 1988 decision (3). This case, the first of its kind reported in Texas, involved medical and hospitalization benefits erroneously paid by an insurer for 6 to 7 months after the policy expired. Again, the overpayments were due solely to the insurer's mistake; the hospital was unaware of the terms of the policy and made no representations to induce the insurer's payments beyond the policy terms. The court here indicated that the hospital could make a strong argument that it materially changed its position by rendering services to the insured in reliance on a continuation of insurance payments. Due to the status of the hospital as an innocent third party creditor in this case, however, it was necessary for the hospital to establish a material change of position on its part.

Both the Nebraska and Texas cases involve litigation wherein the insurer instituted action directly against the physician to recover overpayments. In litigation arising between insurers and their insureds, recovery of overpayments for hospitalization benefits has also been denied, though under different principles discussed later.

If funds owed to one party are mistakenly paid to an innocent creditor of that party, there is no requirement that the funds mistakenly paid be returned.

Case law allowing recovery

Very few reported cases permit restitution in actions directly between an insurer and a doctor. Such cases turn on wrongful actions on the part of doctors, involve situations where failure to order restitution would result in more than the entire bill being paid, or involve incomplete information being provided to the insurer.

One such case in a federal district court in Oklahoma involved an insurer seeking restitution on an overpayment made to a hospital on the part of its insured (4). The action brought directly against the hospital sought injunctive relief, allowing the insurer lawful access to factual medical records of its policyholders, in addition to an accounting of any monies mistakenly overpaid by the insurer. The court granted the insurer injunctive relief and ordered restitution of the overpayment made through mistake of fact. Here the hospital's denial of access to the records was found to be unlawful interference with the insurer's business, thus the hospital was not shown to be an innocent third party creditor.

The same insurer unsuccessfully brought a similar action in a Kansas state court, which denied an injunction, recognizing the general reluctance of courts to grant injunctive relief (5). The Kansas Supreme Court upheld the lower court's ruling that explicitly disallowed the insurer's attempt to reopen old files and to discover whether or not it had a cause of action against the hospital on payments that had been made.

Along a slightly different line of reasoning is an action in a Pennsylvania federal court brought by a hospital against two insurers providing coverage for the same patient (6). One insurer had mistakenly paid beyond its limits on preexisting conditions and sought restitution of excess payment when it learned that the treatment was for a preexisting condition. The second insurer denied coverage altogether. The court found the second insurer liable for the entire amount and ordered recovery of the overage mistakenly paid by the first insurer. Although restitution was ordered, the result was full compensation for the physician, but no more.

Rationale for retention

The Nebraska decision best explains the legal rationale allowing retention of overpayments to doctors.

A recognized practice throughout the health-care industry is the assignment of insurance policy benefits to hospitals and doctors. Allowing insurers to prevail in these cases would jeopardize the use of such assignments. Payment of policy benefits would be made directly to the insured patient, who then should make a separate payment to the doctor. Such a result would dramatically delay and diminish funds transmitted through the insured who may be less able to interact efficiently with the insurer, and who may be reluctant to part with the insurance funds received. By allowing the hospital to retain overpayment, the court places the burden of determining policy limits and payments squarely on the insurer — the only party fully knowing the provisions of the policy.

Payments mistakenly made by an insurer beyond policy limits may be retained by a doctor or hospital who is innocent, who acts in good faith without prior knowledge of the mistake, and who makes no misrepresentation to the insurer.

Alternative approaches

An insurer seeking recovery of funds overpaid to a hospital may also be unsuccessful if its action is brought against its insured alone.

An explanation of the reasoning involved was offered by the New Mexico Supreme Court (7). In order to prevail in an action for restitution, the insurer must demonstrate that the party or parties sued actually possess money that belongs to the insurer. Where an insurer sued only its insured, seeking recovery of overpayments mistakenly made to a hospital, the New Mexico court denied recovery on the basis that the insurer had sued the wrong party. Courts in New Jersey and Georgia have also denied recovery of overpayments of hospitalization benefits in litigation between the insurer and insured based on principles of fairness and equity (8,9). The underlying proposition in these cases seems to be that where an insurer fails to investigate doubtful facts relating to coverage, or where it fails to ascertain the true facts in making an overpayment, restitution will not be ordered.

Although not guaranteed, insurers might expect better success in recovery of overpayments when their action is brought against both the insured and the doctor or hospital that had received overpayment. This joins together in one action the one who had received the overpayment and the party unjustly enriched by the payment made beyond the policy limits.

In the Texas case discussed earlier this was the strategy used, and, although restitution from the doctor was denied, the insurer was able to subsequently litigate against the insured. As a practical matter, a judgment for the insurer against only the insured may very well be uncollectible or subsequently discharged in bankruptcy.

Conclusion

Although the cases discussed are from a variety of jurisdictions, the courts have rendered decisions that appear consistent with the following guidelines:

- Payments mistakenly made by an insurer beyond policy limits may be retained by a doctor or hospital who is innocent, who acts in good faith without prior knowledge of the mistake, and who makes no misrepresentation to the insurer. The funds retained should not exceed the amount actually due for services rendered.
- An insurer is more likely to be successful in recovering an overpayment by pursuing the insured as well as the doctor or hospital in a recovery action. Recovery is not guaranteed to an insurer as against its insured, of course, and may also be denied on a number of grounds.
- The few reported cases that permit an insurer to recover against a doctor or hospital appear to be limited to situations where the physician was not entirely innocent and where a complete recovery was afforded to the doctor by other sources.

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Legislative Affairs

Mental health agency puts new restrictions on psychiatric hospitals

WITH INTENSE SCRUTINY focused on the psychiatric hospital industry, the state agency that licenses such hospitals has moved to protect patients' rights.

The Texas Department of Mental Health and Mental Retardation (MHMR) in December enacted emergency rules designed to halt alleged abuses at psychiatric facilities. The rules took effect immediately and impact 87 private psychiatric hospitals. They will remain in effect for 120 days, then can be made permanent by MHMR.

The new guidelines were enacted amid two statewide investigations of the psychiatric hospital industry by a special state Senate subcommittee and Texas Attorney General Dan Morales. Those investigations have prompted hundreds of complaints against psychiatric hospitals. Top state officials also had pressured the agency to take some action.

The rules, which were announced December 4:

- authorize MHMR to inspect hospitals to ensure they comply with state and federal laws;
- prohibit patients from being admitted unless they personally have been evaluated by a physician who authorizes admission;
- state that if a patient entered the hospital voluntarily and requests a discharge, a physician must examine the patient and provide an assessment within 24 hours; and
- require psychiatric facilities to provide a four-page Patient's Bill of Rights to all patients being admitted.

The investigations of the psychiatric hospital industry grew out of an incident in San Antonio last year in which a Live Oak teenager was picked up by private security agents and admitted to Colonial Hills Hospital against the wishes of his parents. Following that incident, Texas Medical Association helped push through legislation prohibiting psychiatric hospitals and all other health-care facilities and professionals from accepting or making payments for patient referrals.

Senator Judith Zaffirini of Laredo, who sponsored the 1991 legislation and who is a member of the Senate subcommittee, has said criminal and monetary sanctions may need to be enacted to discourage inappropriate admission and treatment practices.

Medicaid, AIDS bills among last-minute action by Congress

AS IT RUSHED TO WRAP up its business before its traditional Thanksgiving-Christmas break, the 102nd Congress took action on numerous health and medical issues, including a compromise on how states raise Medicaid revenues and new AIDS education requirements for physicians.

The new Medicaid regulations, which were sent to the president to be signed into law, put limits on innovative funding techniques states use to increase federal Medicaid matching funds. The measure is a compromise between Congress an the Bush administration, whic wanted to put an end to such fund ing mechanisms. The administra tion's proposal could have cost th state of Texas as much as $1 billio in federal funding.

The bill caps the use of provide tax revenues at 25% of each state' Medicaid program for the next years. States relying on voluntar donations from providers to rais Medicaid money have to eliminat them by October 1, 1992.

The bill also limits state spendin on disproportionate share hospital to 12% of total Medicaid spendin in each of the next 4 years.

Legislation that would mandat continuing medical education on infection control as part of routin credits required for relicensure als gained last minute approval as par of the Health Promotion and Disease Prevention Act of 1991. However, a conference committee was scheduled to resolve differences between House and Senate versions of the bill when Congress reconvened.

The proposed requirements were added in response to concerns about potential transmission of the human immunodeficiency virus from health-care workers to patients. The American Medical Association has said it will aggressively fight federal mandates for state licensure requirements.

Several other health-related actions that occurred just before the congressional recess include:

- International medical graduates — The House passed HR 3508, which would establish AMA's National Credentialing Verification Service as a repository for the credentials of international medical graduates. The bill relies on a private sector approach that will

Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs sections of* Texas Medicine.

NEW PANEL FORMED TO STUDY NURSING HOMES

A LEGISLATIVE OVERSIGHT COMMITTEE has created an advisory work group to help it solve problems at Texas nursing homes.

The panel was created by the Legislative Health and Human Services Board n the heels of a new study showing one third of Texas nursing homes have a istory of violating health and safety rules. Following the release of that reort, Gov Ann Richards called for the immediate closing of the worst homes, reation of special mission teams to crack down on violators, and new laws to rotect nursing home residents.

Laura Smith, special assistant for research and policy development in the ffice of House Speaker Gib Lewis, said the work group was established to dvise the Legislative Health and Human Services Board on nursing home isues. The board is chaired by Lt Gov Bob Bullock. Speaker Lewis is vice hairman.

At *Texas Medicine* press time, the membership of the work group still vas being finalized. Ms Smith, however, said the panel would include a hysician, nurse, and pharmacist, as well as representatives of nursing home roviders, patient advocates, and state agency representatives. Texas Medical Association will be represented.

The work group will not be a voting body, but it is hoped it will provide forum for resolving some disputes between patient advocates and roviders, Ms Smith said. The work group was scheduled to hold its first neeting in mid-January.

help assure that only properly credentialed foreign medical school graduates are licensed as physicians in the United States. The Senate also has approved a version of the bill and has appointed conferees to work out differences with the House version.

- Student loans — AMA is leading a coalition of specialty societies, medical schools, and other educational groups to defeat House and Senate efforts to eliminate student loan deferments. Both House and Senate committees have voted to cut the deferments for medical residents and others, such as members of the armed services, Peace Corps, and VISTA. The Senate bill also restricts the availability of forbearance to residents whose debt exceeds 20% of their income and limits the maximum forbearance period to 3 years. Again, this issue was not scheduled to be resolved until Congress reconvened.

- Tax extender package — Both the House and Senate passed HR 3909 to extend certain tax provisions for 6 months. The bill includes a provision extending deductions until June 30, 1992, for health insurance premiums paid by the self employed. At *Texas Medicine* press time, the bill was awaiting the president's signature. ★

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Science and Education

House of Delegates deals with CME, other issues

IN THE SHADOW OF NEW federal regulations, the TMA House of Delegates took a firm stand on the role of continuing medical education (CME) November 15-16, 1991, at its interim meeting in Austin.

Delegates passed a revised and expanded CME statement designed to provide a basic profile against which all CME activities must be planned and evaluated. The new statement expands previous policy, spelling out specific goals and requirements for CME programs.

Delegates backed a new policy on conflict of interest in the presentation of CME, specifying what types of gifts or inducements constitute a conflict, and requiring disclosure of potential conflicts.

Also adopted was a policy on the commercial support of CME, requiring that TMA retain full control over the content, quality, and scientific integrity of all activities and materials; requiring that presentations of therapeutic options be unbiased; and encouraging the use of generic rather than product trade names in presentations.

The delegates asked the TMA Committee on Continuing Education to develop criteria for the conflict of interest policy and to have them reviewed by the TMA Board of Trustees before including them in administrative rules. The delegates also voted to encourage other accrediting bodies to adopt a similar policy.

The issue of CME and conflict of interest has been in the forefront of the news in recent months, as the federal Food and Drug Administration proposed new rules limiting the role drug companies can play in sponsoring CME activities.

The FDA claims the rules, which dramatically tighten regulations on drug-company-sponsored CME, are an attempt to create a "safe harbor" for independent scientific CME activities not needing regulation under the FDA's mandate to supervise all pharmaceutical promotional activities.

> "THE FDA HAS TAKEN THE EXTREME POSITION THAT ALL CME PROVIDERS ARE IN CAHOOTS WITH THE PHARMACEUTICAL INDUSTRY."

TMA feels the rules are too restrictive, according to James Rohack, MD, College Station, chairman of the TMA Council on Medical Education, who says that while some companies have abused the system, the majority provide helpful and necessary information.

"Congress, which is showered with gifts from lobbyists all the time, has for some reason decided the medical profession isn't acting aboveboard," he said. "As a result, the FDA cracked down extremely hard with proposals that a drug company can give monies to the CME provider, but cannot judge content and is limited as far as advertising.

"The FDA has taken the extreme position that all CME providers are in cahoots with the pharmaceutical industry. I think, in reality, that is not true."

Dr Rohack added that both the pharmaceutical and medical industries have commented on the proposed regulations, which were scheduled to be published in late 1991 or early this year.

TMA, AMA, and other organizations have called on the FDA to give the current voluntary system, put in place May 1, 1991, a chance to work before imposing harsh federal regulations on the process.

In other medical education matters, the House of Delegates:

- opposed consolidation of the State Board of Medical Examiners with other state licensing agencies without prior consideration of its impact on the quality of care in Texas;
- approved a recommendation to urge medical schools and residency programs to offer a risk reduction course during all levels of residency training;
- adopted the recommendations of the AMA task force on medical student and resident abuse, encouraging adoption of the recommendations at all medical schools and residency programs, and called for the Council on Medical Education to establish criteria to monitor implementation of the recommendations;
- adopted a measure calling on the TMA president to encourage medical societies with medical schools or training programs in their jurisdictions to review medical student and house staff officer involvement in local activities to ensure an effective liaison; and
- referred to the Council on Medical Education a measure to study the options available to medical students forced to retake Step 1 of the United States Medical Licensing exam during their third-year clerkship.

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

nformation for this column comes from a variety of sources, including aca-emic institutions, state and federal agencies, and private institutions. To ubmit items of interest, write Texas Medicine, *Science and Education Edi-or, 401 W 15th St, Austin, TX 78701.*

Breast cancer drug taxol shows promise in tests

he University of Texas M.D. Anderson Cancer Center, Houston — A study has shown the anticancer drug taxol to be highly effective for patients with videspread breast cancer. Results of the study, published in the December issue f the *Journal of the National Cancer Institute*, showed a remarkable rate of re-nission among women with breast cancer that had spread to other parts of the ody. Taxol is a substance found in the bark of the rare western Pacific Yew ree. The report states that of the 25 participants, 3 women (12% of the pa-ents) showed complete remission, and another 11 women (44% of patients) howed partial remission. Taxol's cancer-fighting mechanism allows it to break own parts of the cell called microtubules, thus preventing malignant cells from lividing, according to Frankie Holmes, MD, principal author of the study. She aid researchers are trying to develop a synthetic substitute for taxol, which vould help solve the problem of the drug's scarcity.

Powerful computerized cardiac mapping system developed

Baylor College of Medicine, Houston — A nonsurgical cure for life-threat-ening irregular heartbeats may soon be available, thanks to a computer-zed cardiac mapping system being developed at the DeBakey Heart Center at Baylor College of Medicine. The 1,000-channel system will replace a 128-channel system developed earlier at the heart center and should be ready for esting on humans early this year, according to Antonio Pacifico, MD, assis-ant professor of medicine at Baylor. Computerized cardiac mapping is used to pinpoint areas of the heart where electrical disturbances affecting the beating rhythm originate. When the arrhythmia is severe, it can cause sudden cardiac death. The new system will provide scientists with a more powerful tool to study ventricular tachycardia. Knowledge gained from that study should lead to a nonsurgical cure, the study said.

New laser technique could replace tissue biopsies

The University of Texas, Austin — A biomedical researcher at UT-Austin is working on a process that could ultimately replace tissue biopsies with a painless optical scan for cancerous lesions. Rebecca Richards-Kortum, PhD, assistant professor of electrical and computer engineering, has received a $204,000 grant to devise a process that will identify lesions by the light they radiate. According to Dr Richards-Kortum, precancerous tissues emit fluorescence in a manner different from healthy tissue, and the differences can be used to provide an early diagnosis. The technique, she said, is about 10 years away from routine use.

Researchers study therapeutic uses of plants

The University of Texas Health Science Center at San Antonio — Experi-ments in phytotherapy, the age-old use of plants for medicinal purposes, are yielding some noteworthy results. Using the aloe vera plant, the Oriental "reishi" mushroom, and the herbs, roots, and flowers of Japanese "kampo," scientists are learning how these ancient plants reduce pain and fight disease. Most promising is a discovery that the aloe vera plant contains substances that spur the immune system to make new lymphocyte cells, said Wendell Winters, PhD. Other studies have shown that aloe vera's active ingredient may guard against aging of the skin and circulatory system. Dr Winters and other UTHSCSA researchers recently shared their findings with overseas peers at the first International Congress of Phytotherapy in Seoul, Korea.

HealthFind program links physicians, rural communities

LIKE A LONELY HEART LOOKING for a spouse, many Texas rural communities have come a courtin', hoping to find a physician to bring them out of medical isolation.

HealthFind, a program supported by TMA and coordinated by the Texas Center for Rural Health Initiatives, is not quite a computer dating service, but it is designed to introduce physicians seeking jobs to rural communities needing physicians.

The need in Texas is great. There are 18 counties in the state without a physician, and dozens of other counties and communities that have been designated as medically underserved by the federal government.

HealthFind works with both physicians interested in rural practices in Texas, and communities that wish to attract a physician. The program teaches local community leaders how to analyze their medical needs, as well as how to market themselves to prospective physicians.

HealthFind sponsors a series of workshops for community leaders and "exchange" meetings to get prospective physicians and communities together. The next scheduled exchanges are in September 1992 and April 1993. The registration fee for residents is $30 to attend one exchange or $55 to attend both. For practicing physicians, the fee is $125 for one exchange and $200 for both. For participating communities to attend a HealthFind training workshop and one exchange, the fee is $400, and for a workshop and two exchanges the fee is $700.

Other organizations sponsoring HealthFind are Texas Hospital Asso-

ciation, Texas Department of Health, Texas Association of Community Health Centers, Texas Higher Education Coordinating Board, Texas Health Care Association, Texas Academy of Family Physicians, Texas Rural Communities, Inc, and Texas Chamber of Commerce.

For more information about the program, contact the Center for Rural Health Initiatives, PO Drawer 1708, Austin, TX 78767, or call (512) 479-8891.

VALLEY PHYSICIAN HOSTS BANQUET FOR HONOR STUDENTS

MARIO RAMIREZ, MD, (at left) meets with University of Texas at Austin President William Cunningham, PhD, a featured speaker at a banquet for more than 1,000 high school honor students from Starr, Hidalgo, Jim Hogg, and Zapata counties on November 14 in Rio Grande City. Dr Ramirez, vice-chairman of The University of Texas Regents, helped organize the program, which honors high-achieving students and encourages future excellence. Other featured speakers were Miguel A. Nevarez, PhD, president of The University of Texas-Pan American, William Mobley, PhD, president of Texas A&M University, and Lt Col Sidney M. Gutierrez, a NASA astronaut who flew on the July 1991 life sciences space shuttle mission.

Southwestern Medical Center receives $85 million in gifts

FOUR GIFTS TOTALING $85 million to The University of Texas Southwestern Medical Center in Dallas include three of the largest donations ever made to an institution of higher learning for medical research, according to school officials.

The donations include:

- a $30 million grant from the Excellence in Education Foundation to support research in molecular genetics and human disease;
- a $25 million gift from an anonymous Dallas donor, who pledged $10 million to complete a new research building and $15 million to complete the establishment of two centers for cancer research;
- a $25 million challenge gift from a second anonymous Dallas donor to raise additional endowment for research, with emphasis on neuroscience, cancer developmental biology, and genetics; and
- a $5 million challenge gift from the Southwestern Medical Foundation to raise matching funds for research.

"This is a landmark day in the history of our medical center," said Kern Wildenthal, MD, president of UT Southwestern. "These new contributions will enable us to make major strides in our research programs."

Physician Recognition Award forms available

THE AMERICAN MEDICAL Association created the Physician's Recognition Award in 1968 to recognize and commend physicians for voluntary participation in continuing medical education activities.

Each year, approximately 24,000 physicians apply for the PRA certificate. It is widely accepted by many states and medical organizations as verification of the fulfillment of mandatory CME requirements and offers tangible evidence to patients, colleagues, and the public of physicians' personal commitment to continuing medical education throughout their careers.

Applications for the PRA recently were mailed to all Texas physicians not holding a current certificate. The TMA Committee on Continuing Education encourages all physicians to actively participate in CME activities and to document this participation through the Physician's Recognition Award program.

PRA application forms and updated information booklets are available from the AMA Office of Physician Credentials and Qualifications, 515 N State St, Chicago, Il, 60610, or by calling (312) 464-4672. They may also be obtained through the TMA Medical Education Department, 401 W 15th St, Austin TX 78701, or call (800) 880-1300 or (512) 370-1446.

Medical Library Association compiles listing of cancer texts

THE CANCER SECTION OF the Medical Library Association has completed the new 1988-91 edition of *Clinical Oncology: A Selected List of New Books 1988–91*, a review of approximately 200 current clinical oncology texts.

Full citations, approximate prices, journal review locations, and Brandon/Hill list information is given for each title. Also included is a review including audience, focus of the text, and other information helpful in the selection of cancer texts.

The books are $10 each. To order, send a check payable to "MLA-Cancer Section" to Susan J. Michaelson, Texas Medical Association Library, 401 W 15th St, Austin TX, 78701. For more information, call Ms Michaelson at (800) 880-1300 or (512) 370-1541. ★

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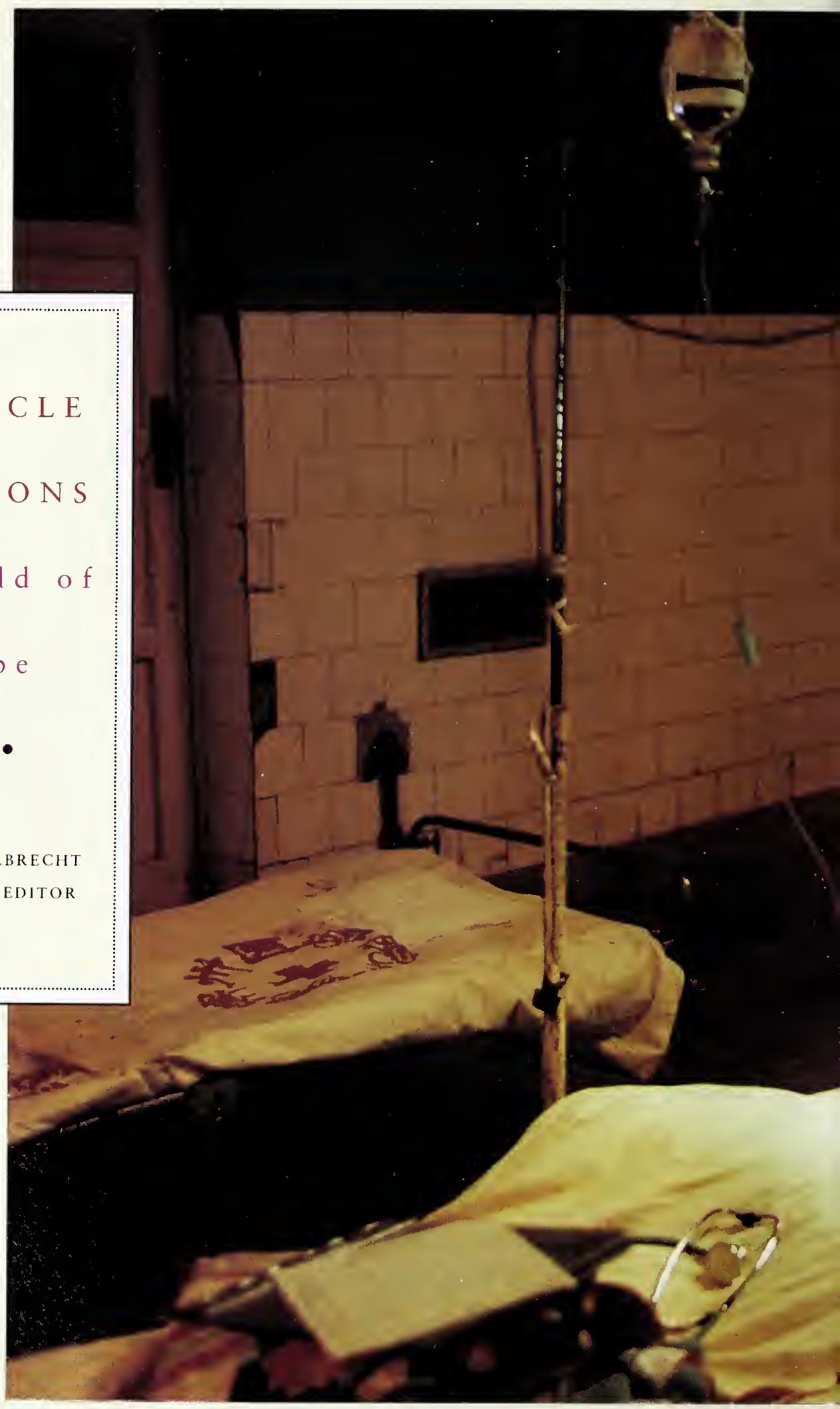
MIRACLE MISSIONS

a world of hope

• • •

BY
LAURA J. ALBRECHT
ASSOCIATE EDITOR



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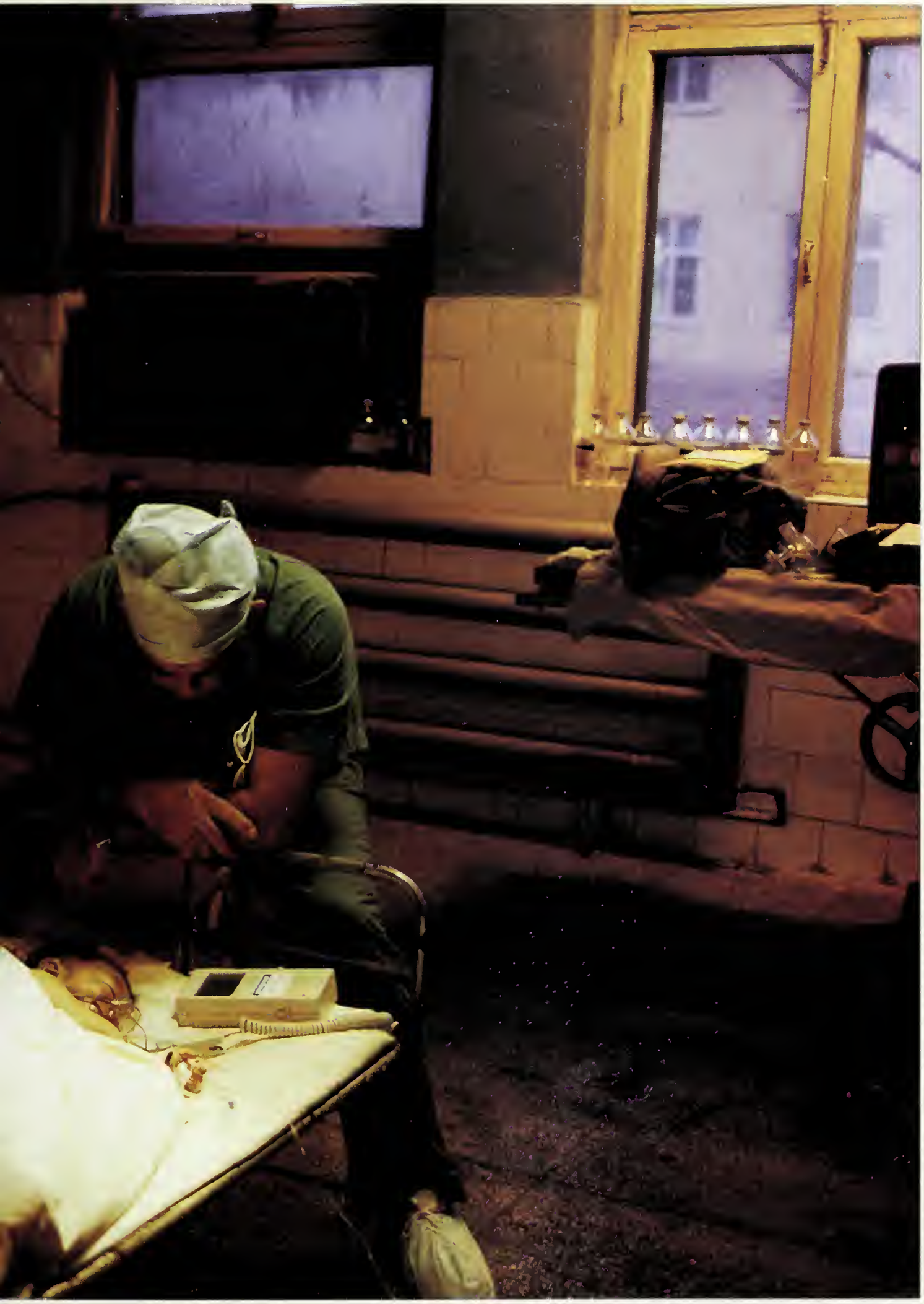


MIRACLE MISSIONS

a world of hope

They heal, learn, teach, and care.

Texas physicians on medical missions. Volunteering their skills and time in Third World countries.

It started with the plastic surgeons, who discovered that in a few hours they could change lives. More recently, ophthalmologists and orthopedic surgeons have become part of the teams and cardiovascular surgeons are considering a role.

Some of the doctors work with private organizations that coordinate trips, while others join groups sponsored by churches.

Trips are planned to Central America, Africa, China, the Philippines, and other countries where access to care is limited or nonexistent. Every conceivable item needed for surgery is taken on the mission. The surgical facilities range from one extreme to another. Primitive to civilized. Open air to tiny, cramped rooms. Modern equipment to relics to a combination of both await the doctors and medical teams. Infection control takes on a new meaning. Gloves are reused in conditions not requiring complete sterilization. Surgical instruments are boiled and dried in the sun.

Surgeons, anesthesiologists, nurses, and ancillary staff all join forces to provide care. There are times when even family and friends assist in surgery.

The surgeons who share their experiences on the following pages of Texas Medicine *represent a network of doctors who understand that their skills are cherished in other parts of the world. After caring for others in foreign lands, they return to their practices in Texas with renewed respect for their profession and themselves.*

Ted Spears, MD
Austin orthopedic surgeon

Ted Spears, MD, envisione using his skills to treat children in l Salvador. Instead, he found himse in a war.

As part of the Austin Smiles o thopedic team, which included Jo Abell, MD, Dr Spears was going t Central America to treat children su fering from clubfeet. "When we go there the hospital was not able to ac commodate the five plastic surgeon in addition to our procedures," say Dr Spears. "We were somewhat dis appointed, but what do you do wit two extra orthopedists in El Salvado during a civil war?"

Send them to a military hospital.

"We were not unwilling, but w were a bit reluctant," says th Austin orthopedic surgeon. "W thought we would be doing surger on children and found out we wer going to a military hospital to trea trauma cases. What we saw ther were cases that American doctor had not seen since Vietnam. Civilia trauma, such as gunshot wounds can be pretty grisly, but it's nothin like you see in combat."

One incident involved a 21-mem ber military patrol hit by rocket-pro pelled grenades. Soldiers were throwr from their vehicle and viciously fire upon by Communist guerrillas usin AK47s. Five were killed and 16 trans ported for treatment.

"I had experience in trauma, bu I was a little bit shocked with what saw," says Dr Spears. "But it wa real life and absolutely fascinating They set up in an open air surgica theater and started operating. Not 5 feet away was a concession stanc where they were selling Coca-Cola and candy. And someone was sittin near the surgical area smoking."

Another aspect of his experience that remains with Dr Spears was the age of the soldiers. "These soldiers, carrying M16s, were children of 14 and 15 years of age, and some even looked younger. They were watching television in the concession area. I looked over at them

nd discovered they were watching artoons. They had the same innoent look my two children have hen they watch cartoons."

Dr Spears learned also about the olitical connection between health are and the war. "The average citien in El Salvador will tell you up ont the Communists are intentionlly wounding, not killing, the chilren with land mines and all types of xplosive devices. Explosives are laced in banana or coconut trees here the children play. There is just nough of a charge to blow off an xtremity and maim the child, but ot kill him. If a child is killed, the arents are back to work and there is o economic drain. However, the vounding of a child means two dults will be less likely to work, and hat places a strain on the economy. There are a lot of stories from beeaved parents about the terrorism."

The handling of trauma truly mazed Dr Spears, but a country mbroiled in civil war has become ccustomed to these types of cases. "The doctors' skills were so finetuned there was nothing that we could teach them. My expectations were to go down there and shed all this knowledge, but it was definitely a mutual learning experience. It was a large dose of humility and professional respect to work with these doctors and perform under the conditions they work under."

TED SPEARS, MD

PHOTOGRAPH BY JIM LINCOLN

Boosting the morale of injured soldiers was one of Dr Spears' roles. "The fact that we were consulting on cases was good for morale," he says. "Seeing American doctors in the hospital created a sense of credibility for the military medical system." Dr Spears adds that Austin Smiles was not in El Salvador to make political statements.

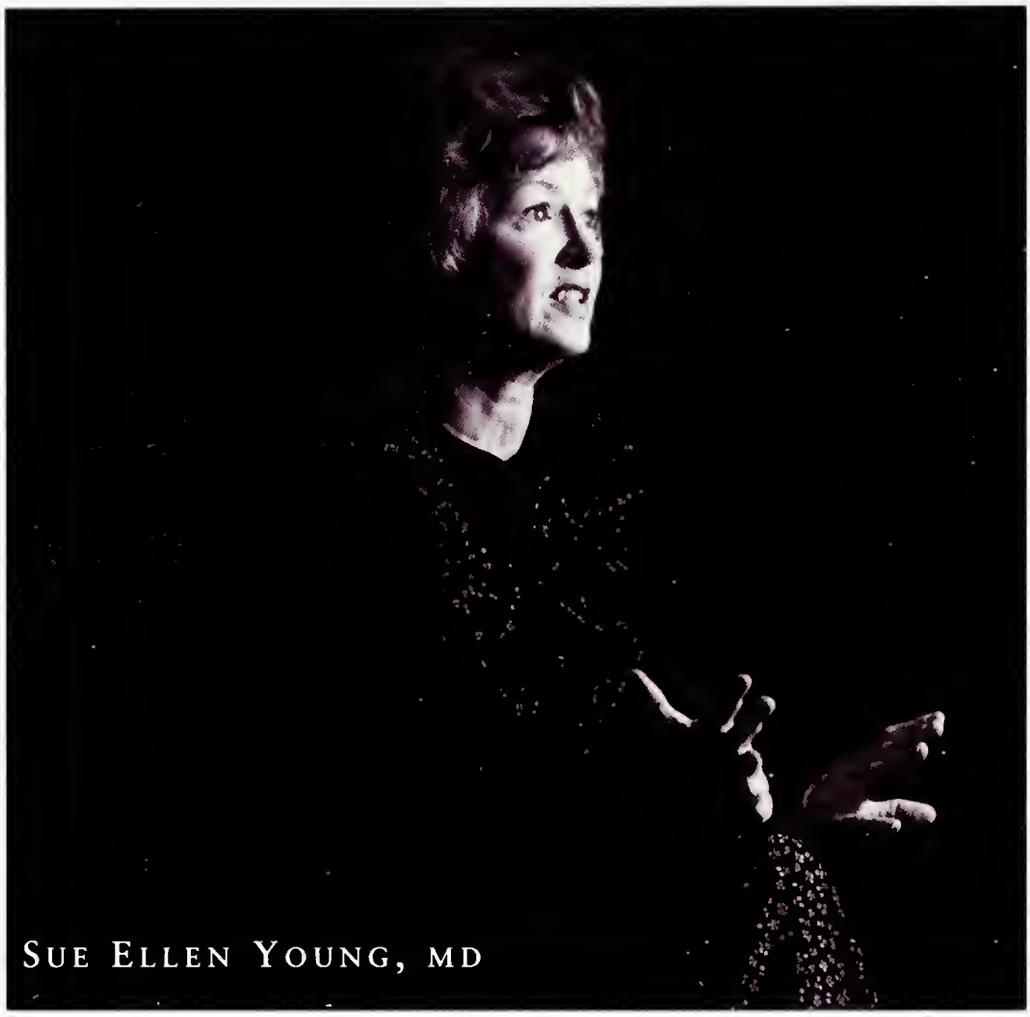
Although most of his patients were soldiers, Dr Spears recalled one elderly female military dependent who needed a hip implant.

"This frail, little 70-year-old lady had broken her hip and was in need of an implant. Dr Abell does a lot of reconstructive hip procedures. After viewing the x-rays, we said it was an easily treatable case and we would be happy to perform the surgery. The patient was prepped and ready for anesthesia. The resident appeared in the operating room with the only available implant, which was obviously too large for the patient. In 5 years, they hadn't found anybody who was large enough that they could use it in. And here we have this lady on the table fixing to be put under and all of a sudden we realize there is no way we're going to do this implant. We had to tell the lady the surgery was called off. And she was so understanding. That's what impressed me about the patients. They are so happy just to get any form of medical care that they are grateful and gracious."

Unnerving times are bound to occur when spending a week in a country involved in a civil war. "I was having dinner one night on a veranda with Dr Abell and the nurses when someone drove by less than 50 feet away and cranked off about 50 rounds from a automatic machine gun. It was a deadening roar. The maitre d' came out very composed and invited us to come inside because he was afraid it was going to rain. However, he didn't say what it would be raining."

"It was an incredible adventure. The patients look up to you with confidence, and that's something a lot of doctors in America don't see."

Dr Spears still finds his trip "unbelievable" and would like to return. "Those people absolutely embrace you. They look up to you with confidence, and that's something a lot of doctors in America don't see."



SUE ELLEN YOUNG, MD

PHOTOGRAPH BY JIM LINCOLN.

SUE ELLEN YOUNG, MD
Austin ophthalmologist

TRAVELING TO AFRICA ON A medical mission came at the "right time in life" for Sue Ellen Young, MD.

Dr Young was lured to Kenya, a land where 20 ophthalmologists provide treatment to 20 million people, in 1989. The Austin physician soon discovered the reality of practicing her specialty in a Third World country.

Welcome to a country where owning a pair of eyeglasses is a status symbol; open air facilities are the norm for operating rooms; lights are powered by generators; and instruments are dried in the sun after being submerged in boiling water for sterilization.

Away from the safe confines of an operating room in the United States, Dr Young found she no longer had access to high-tech instruments or assistance from an experienced surgical team.

Because she was in a new environment, the Austin physician was concerned about the safety of her patients. Primitive facilities provided little relief to an underserved population still 20 years behind in the area of eye surgery.

"I was scared I wouldn't be able to perform in a situation where I had absolutely no experience," says Dr Young. "But once I started surgery it was a wonderful experience."

The eye surgery clinic, located in a small village north of Nairobi, was a refuge for individuals seeking the miracle of sight available to them from American physicians. Anxious patients numbering into the hundreds, barefoot, and carrying their life's possessions, would walk 20 t 30 miles and wait in line to b screened by physicians for treat ment. Most had never been expose to a doctor's care.

"It was by word-of-mouth the would learn the eye care team wa at the hospital," says Dr Young "Lines would form early and ever day would get longer. We were ther for a limited time (3 weeks) and fo cused on providing treatment tha would make a difference in thei lives. We were looking for the wors conditions to treat in this popula tion. The hardest part was to priori tize what we could do for these peo ple. Every day we had to turn peopl away and that was the hard part For some individuals who could no see out of both eyes, we would oper ate on one of the cataracts just t help them help themselves."

A language barrier hampere the collection of medical histor from patients. "We had to trus they would be fine and they had t trust us."

Surgery began each day at firs light and concluded as darkness fell Surgeons were assisted by famil members, friends, and local resident who had no experience with eye care much less assisting during surgery.

"We just hustled and tried to d as much as we could," she says. "W would go home every night exhaust ed, but feeling great. We wouldn' even stop for lunch because we felt i we worked just a little harder w could help another person."

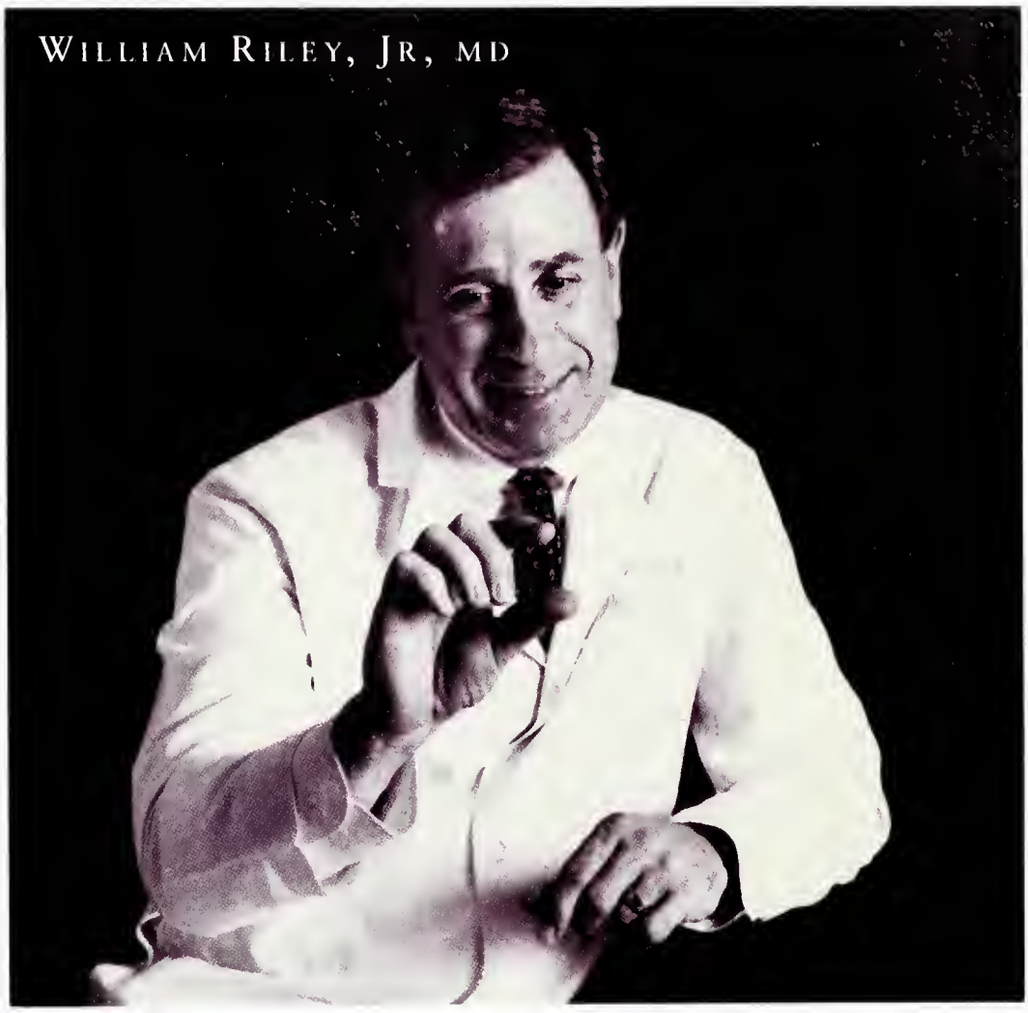
The exhilaration didn't end wit surgery. "Patients would get so ex cited after we would remove thei eye patches," says Dr Young, wh wants to continue her medical mis sions. "Oh, just to see their faces."

Many of the problems Dr Youn saw could have been prevented wit proper education. The absence o personal hygiene within the popula

"The nicest part about the whole trip was that we could be doctors. We saw a need and took care of it. That was the best part because we were doing what we were trained to do."

on led to infections that resulted in lindness. She and other physicians ıared their knowledge of cataract ırgery with local physicians.

"There was just a total lack of ıre," she says. "And since we were ıere for such a limited time, we foısed on what we could do to make difference in people's lives."



PHOTOGRAPH BY HENNY VAN DIJK

WILLIAM RILEY, JR, MD
Houston plastic surgeon

VILLIAM RILEY, JR, MD, vas overwhelmed with what his kills as a plastic surgeon accomlished on his first medical mission o the Philippines in 1978.

He was so amazed that upon his eturn home he began to plan for nore medical trips, thus planting the eed for the creation of Operation Rainbow (see sidebar, next page).

"I had never traveled to a Third Vorld country, let alone worked in ıne," says Dr Riley, who has since ıacked his bags for more than 25 rips to China, Central America, and he Philippines.

He piqued the interest of others vhile sharing his medical mission xperiences.

"I had one surgeon with me durıng the first trip. We talked about vhat we did and decided to return ince we felt strongly about it," says Dr Riley. "The more we talked about it with other people, the more interested they became and one thing led to another."

Administering medical care to individuals living in impoverished countries has changed the way Dr Riley looks at life and his profession.

"It keeps things in perspective in the way we have to practice medicine in this country now; the things we have to be concerned about day-to-day are not the same, and the motivating reasons why we all went to medical school are reinforced," he says. "We've been forced to do certain things because of the pressures of the times. But when you get to a Third World country and you're participating in a service and education like this, it's more of a pure motive of why you went to medical school. It's just an opportunity you don't have at any other place."

Although Dr Riley has treated adult patients while on Operation Rainbow missions, the emphasis is on children.

"Our focus has been on the children because I think that's where we can have the greatest impact," says Dr Riley. "The stories are moving and emotional."

Families have traveled great distances seeking treatment for their children. Most frightening is the abandonment of children in rural China because of deformities.

"We have encountered situations where parents have refused to abandon their children and they have become outcasts in their families, country, and culture," says Dr Riley. The burden is lifted when surgery is performed, which in turn reintroduces the family back into the culture.

A major thrust of Operation Rainbow is sharing knowledge with physicians in other countries.

"I think the service aspect of what we do is certainly gratifying and that is the way these programs usually get started," says Dr Riley. "But once you get started and involved in this type of work, you realize that you could provide these kinds of services forever and there would still be more work you could get done.

"With a few good instruments and a trained pair of hands you can have such an impact on a person's life."

Operation Rainbow

Operation Rainbow volunteer physicians are changing lives.

Doctors from across the United States have been giving their time for 13 years to provide reconstructive surgery to children in Central America, China, and the Philippines. A team is scheduled for a trip to Russia in May.

"What our surgeons do for children literally transforms their lives overnight," says James Cruz, program director for the Houston-based international organization. "You can be the most intelligent individual walking the face of the earth, but with a deformity, society is not going to allow you to succeed. In 2½ hours we can change an individual's life."

Nearly 3,000 children have benefited from the organization founded by William Riley, MD, of Houston. Mr Cruz says a typical 7-day mission involves 200 cases with physicians working from 7 am to 7 pm. Operation Rainbow provides not only surgical services, but postgraduate education to the host country physicians. The cost for preoperative, operative, and postoperative care is $200 per child.

> *"What our surgeons do for children literally transforms their lives overnight."*
>
> — James Cruz
>
> Operation Rainbow program director

"If you really focus on providing classroom as well as hands-on education, then at some point they become increasingly self-sufficient," says Mr Cruz. "Part of our philosophy is to make a long-standing commitment so we can work in the country on an ongoing basis."

Operation Rainbow is dedicated to providing health care in rural areas of Third World countries. A "site visit" is conducted to determine the medical needs of an area. Once this process is completed, a program is designed to determine what facilities and personnel are available in the country. "We are not going to serve anyone's needs if we pop into an area and say, 'Here is what we are going to give you,'" he says. Programs are based on treatment needs, facilities, and availability of personnel.

"We think Operation Rainbow is a fun and unique program," says Mr Cruz. "And we have a lot of good individuals who make it happen."

Guide to Operation Rainbow

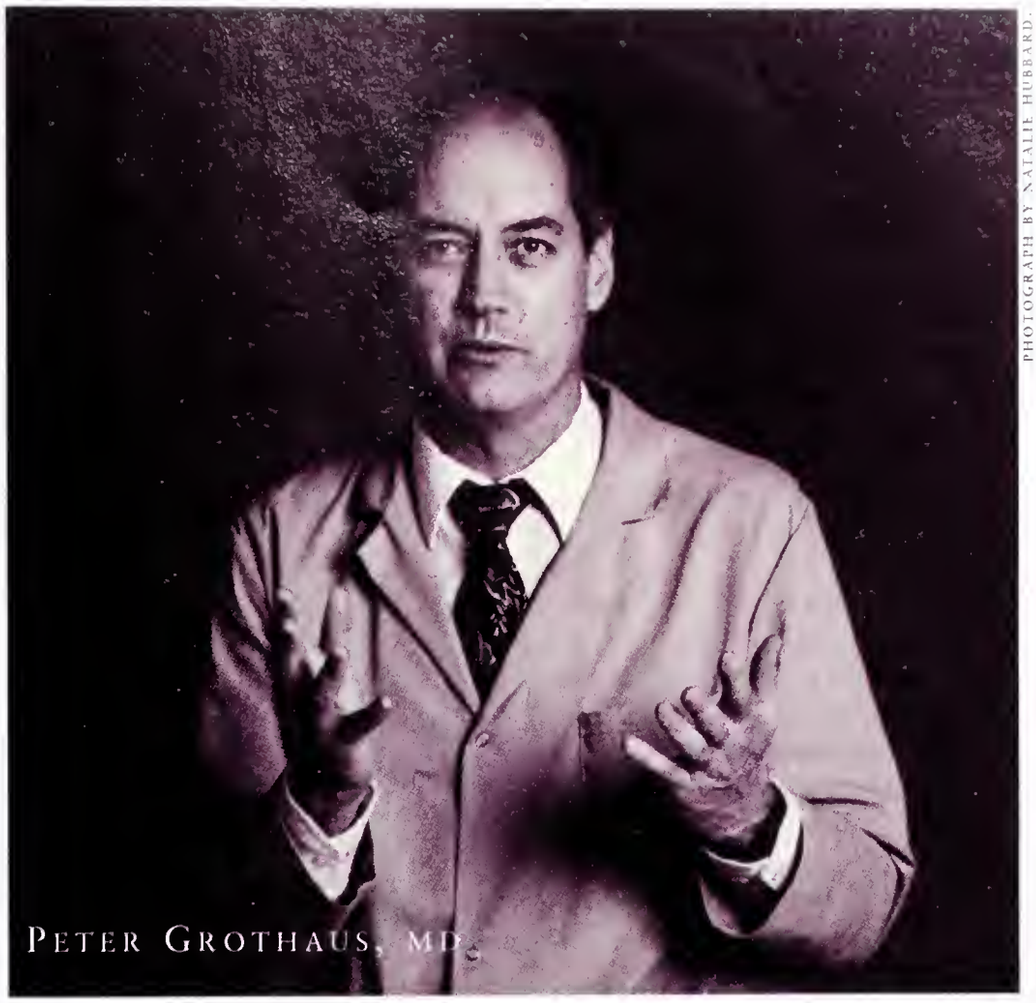
- Founded in 1978 by William Riley, Jr, MD, of Houston.
- First medical mission was to the Philippines.
- Organizes, funds, and oversees an international service program that delivers free plastic and orthopedic surgery to indigent children.
- Surgeons from the US, Australia, Central America, Philippines, and China have provided their skills free of charge to the program.
- Physicians pay their own trip expenses.
- Only board-certified or board-eligible physicians are selected for the program.
- Medical mission planned for Russia in 1992.
- Supported by the American Society of Plastic and Reconstructive Surgeons and the Plastic Surgery Education Foundation.
- Currently evaluating a domestic program in Texas.
- Considering addition of ophthalmology and cardiovascular services.
- Contact: Operation Rainbow, 4665 Sweetwater Blvd, Suite 110, Sugar Land, TX 77479, (713) 980-0088 or FAX (713) 980-0444.

"And the ultimate goal is to provide education along with replenishing and enriching the medical resources in these communities so these problems can be taken care of by the local physicians."

Dr Riley does have a concern about the perception some members of the general population have about medical missions.

"One of the objections people have about overseas medical missions is the fear that needs at home are being ignored," says Dr Riley. But, he says, it seldom occurs that children are not provided the kind of treatment in the United States that is traditionally nonexistent in Third World countries.

"I tell people if they can find a child who needs reconstructive surgery, bring them into my office and we'll figure out a way to get those services to them."



PETER GROTHAUS, MD

PHOTOGRAPH BY NATALIE HUBBARD.

PETER GROTHAUS, MD
Temple plastic surgeon

ENGRAVED IN DR PETER Grothaus' thoughts about his medical mission to El Salvador are the children.

"It's interesting to see how tough these children are after surgery," says the Temple plastic surgeon when describing his cleft palate patients. Just to get to the hospital, young patients travel for days with their families on foot and aboard buses. And they are up and walking home the day after surgery. "They're much, much tougher than we are."

Due to the time restraints of the trips, which last only one week, Dr Grothaus sees many of his patients for the first time in surgery. "We do get to play with some of the kids, but sometimes we just don't get the opportunity."

Three patients come to mind when Dr Grothaus recalls his trip. "I operated on a brother and sister who both had their clefts repaired and I remember watching them play afterwards. Another was a young man who obviously had spent most of his life with a deformity. After surgery I remember he would rub his lip all the time because in the past he'd had a big hole there, a cleft. Now for the first time he was able to actually close his mouth. He would just sit and stare into the distance while touching his upper lip because now he *had* an upper lip."

Since most of the cleft surgery cases are very similar, extensive planning is unnecessary, which enables the team to do about 80 to 100 cases.

Although not American operating rooms, Dr Grothaus found the surgical facilities adequate, not the stereotypical "jungle medicine" setting expected in a Third World country. An earthquake had destroyed the hospital so the team found themselves working in a converted school.

Even though few complications were reported, Dr Grothaus says the infection control would make "some people's hair stand up on end, but they were doing the best they could under the circumstances." He remembers some instances when uninvited guests — such as flies — filtered into the operating room.

"We're not just going into a Third World country, performing surgery and then disappearing into the sunset."

Although the American doctors are generally well accepted, there are some mixed emotions about their reasons for practicing in a foreign country. "The people who invite us are very pleased and excited," says Dr Grothaus, who sees his role as

helping to share the patient load with local physicians. "The reactions of the local plastic surgeons vary. They are competent and have probably done more of these procedures than we have. However, they just don't have the time to do all the cases."

Dr Grothaus made his first trip to El Salvador in 1990 and says he found some changes upon his return in 1991. Times were still tense due to the ongoing civil war.

"There were army personnel on every corner so they didn't encourage us to walk out and about. It was difficult to mix with the general population."

Health care isn't ignored even though the country has been devastated by natural disaster and war. "They are very concerned and aware, but they just don't have the money for health-care programs."

He didn't make the return home without bringing back new knowledge. "Anytime you have the opportunity to do a specific surgery daily, you will improve, learn new things, and think of new ideas."

George Thorne, Jr, MD

George Thorne, Jr, MD
Austin ophthalmologist

There is a patient that Austin ophthalmologist George C. Thorne, Jr, MD, remembers vividly from his medical mission with Austin Smiles to El Salvador.

"An 80-year-old woman was sitting in a room the morning after surgery covered with an old shawl waiting for me to take her patch off. I put a pair of glasses on her after removing the patch. I didn't pay much attention to it and went off to see a few more patients. Upon my return, I noticed she was twirling the threads in her shawl, so I knew her vision was adequate. She was wearing a smile from ear-to-ear. I realized that I did something to change a part of that person's life."

Dr Thorne learned a lot on his medical mission to a Third World country.

"The whole purpose of the trip was not for me to go down there and stir up a few cases and leave," says Dr Thorne. "I don't need to start another practice. The true purpose was to elevate the level of medical care in the community. The best way for me to do that was training residents."

"I have a rule that I'll help anyone who will help themselves, and these people were really trying, so I felt very good about helping."

Working within the program, Dr Thorne was able to share his knowledge to enable residents to become more competent at cataract surgery, glaucoma treatment, and implants.

"The residents were absolutely thrilled with the opportunity to learn something a little bit different," says Dr Thorne.

A language barrier and absence of ophthalmology textbooks proved to be a hurdle for Dr Thorne and the residents to overcome. "They now have one textbook in their library," he says. "It's one I took as a gift, but I am trying to procure more textbooks because the need is there."

Residents and nurses were eager to learn new techniques and fine-tune their skills, which left Dr Thorne with feelings of enormous satisfaction.

"It was fairly obvious they (the residents) had good hands and a reasonable understanding of what was happening, but they really hadn't fine-tuned a lot of the procedures," says Dr Thorne. "I felt when I left I could take one of my

Austin patients into that operating room, assist the resident during surgery, and the patient would walk out with very good results. And that's kind of a good feeling."

The appreciation displayed by the patients before, during, and after treatment left Dr Thorne with lasting memories.

"One of the more interesting aspects about El Salvador is that people are genuinely interested in one another," says Dr Thorne. "There was none of the pushing or shoving to get to the front of the surgery screening line. They were very pacific and grateful for whatever you could do for them. These are the things that make you want to go back."

The medical mission gave Dr Thorne a different perspective on his contribution to medicine and offered the opportunity to reflect on health care in the United States.

"It's easy to get bogged down in our day-to-day activities," he says. "People have developed an attitude that medicine is a right and 100% successful at all times.

"We take for granted what really good medical care we have," says Dr Thorne. "And we take for granted clean water, sanitation, and good food to eat." ★

Austin Smiles

A child in El Salvador undergoes reconstructive surgery to correct a severe deformity. The mother visits the child during recovery. However, the surgeon has done such a remarkable procedure, the mother doesn't recognize the child. Eventually, doctors are able to convince her it is her child.

Barbara Ward, executive director of Austin Smiles, has the privilege of seeing these medical miracles.

"These people are so trusting when they see a white coat and a smile," says Ms Ward, who oversees the organization's operations. "They are willing to trust the doctors with their most precious gift — their children."

Created in 1988 under the direction of the Austin Society of Plastic and Reconstructive Surgeons, Austin Smiles has focused on providing care in Central America and Mexico.

As executive director, Ms Ward oversees the planning of the trips, which can number three to four each year, and orchestrating the location of 25 or more people at any given time on the trips. She makes arrangements for travel and accommodations for the medical teams during their week-long stays, communicates with the host country's government and medical representatives, and assists in assembling the mission team of doctors, nurses, and support staff.

"Generally, I see that the trip is not too stressful on everyone," says Ms Ward. "It's hard to do when the doctors are in surgery for 12 hours every day in close quarters.

"It is exhausting physically and emotionally for the doctors and surgical teams."

Prior to each trip, team meetings are conducted to acquaint mission participants with the program and procedures. "These meetings are so important to acquaint the physician with the conditions. I don't care how many pictures you show them, it is still not reality until you experience it. We can't afford not to have a team effort," she says.

Ms Ward sees changes in the physicians when they return from the trips.

"Sometimes doctors forget they are making a difference in people's lives," she says. "These medical missions help to put all that training into perspective and bring back the feeling and giving."

Guide to Austin Smiles

- Founded in 1988 by the Austin Society of Plastic and Reconstructive Surgeons. Founders are Patrick Beckham, MD, Jim Cullington, MD, and Jim Fox, MD.
- Medical missions using skills of plastic surgeons, orthopedists, and ophthalmologists are concentrated in Central America and Mexico.
- Physician pays own expenses (about $500 per trip) and generally sponsors a team member.
- Program encourages participation from physicians outside of Austin.
- Austin hospitals providing program support are Seton Medical Center, Brackenridge Hospital, and St David's Health Care System.
- Continued goals are to emphasize joint effort between plastic surgeons, other specialties, and the community.
- Contact: Austin Smiles, PO Box 26694, Austin, TX 78755-0694, (512) 451-9300.

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Medical Economics

Council on Health Facilities conducts managed care review

MANAGED CARE, TOUTED for years as the wave of the future in medicine, is no longer a "someday" proposition: it has arrived.

And to help physicians cope with the rapid changes now taking place, TMA's Council on Health Facilities and staff have launched a Managed Care Review Program, designed to assess the numerous managed care plans available and to assist physicians in dealing with the problems they create.

The number of fee-for-service patients seen by doctors has steadily declined in the last decade. Since 1987, the number of Texans enrolled in HMO plans has more than doubled, from approximately 1 million to slightly more than 2 million in August 1991, according to the State Board of Insurance. Considerably more are believed to be enrolled in PPOs and other managed care plans around the state. The PPOs in Texas have almost doubled in just the past year, according to a report by Marion Merrill Dow.

Nationwide, fee-for-service patients have dropped from about seven out of eight in 1984 to about one out of five today, according to SMG Marketing Group of Chicago. Projections are that by 1997, only 12% of doctor-patient contacts will be on a fee-for-service basis. The balance will go to managed fee-for-service, PPOs, and HMOs.

This revolution in medical care delivery, seen by many as a way to contain the skyrocketing costs of medical care, is having an unwanted side effect for many physicians: the "hassle factor."

Increasingly, both the government and private insurers have become involved in the medical decision-making process in ways that are, at best, an unwelcome intrusion into the autonomy of a physician, and at worst, a barrier to quality health care for millions of Texans and other Americans.

The Managed Care Review Program's objectives, according to Karen Batory, TMA director of health-care delivery, are:

- to keep physicians informed of managed care issues through TMA publications and other communications;
- disseminate information about managed care plans to help physicians make informed decisions about participation;
- meet regularly with managed care companies to strengthen physician rapport with carriers' medical directors and work directly with carriers to resolve disputes with member physicians; and
- strengthen coalitions with large employers in private industry by inviting them to discuss what employers are demanding from the health-care industry.

"I think we are providing physicians with some extra weapons to deal with the problems, so they don't simply give up because the hassles have beaten them," said Ms Batory.

Since September, the Council on Health Facilities and TMA staff have met with medical directors and other key personnel from Blue Cross and Blue Shield of Texas, AETNA, Travelers, CIGNA, American Health Network, and Austin Diagnostic Clinic. Meetings were planned in January with PruCare and others.

The council and staff have also met with officials of the Employee Retirement System of Texas, the state agency that administers the health insurance plans for approximately 400,000 employees and dependents of state agencies and state colleges and universities.

As a result of these meetings, TMA has been able to deal with a wide range of physician problems ranging from simple coding problems to attempts by carriers to interfere with doctor-patient relationships, according to Ms Batory.

She added that TMA has also begun to build coalitions with key business representatives to determine what major employers expect from the health-care industry. The association plans to use the information gained through the series of meetings to identify broad spectrum problems in managed care requiring a regulatory, legislative, or legal remedy.

She also added that physicians are encouraged to inform TMA about problems they are having with managed care insurers by writing, calling, or preferably submitting the problem on a TMA "hassle factor" form (see p 57).

For more information about TMA's Managed Care Review Program, contact Karen Batory, TMA Health Care Delivery, 401 W 15th St, Austin TX 78701, (800) 880-1300 or (512) 370-1405.

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

TMA SPONSORS MEDICARE PARTICIPATION WORKSHOPS

BARBARA HARVEY, DIRECTOR OF staff services, Medicare, for Blue Cross & Blue Shield of Texas, listens to a question from the audience recently at a TMA workshop in Austin. The session, "Preparing for RVRBS: Your 1992 Participation Decision," was one of 15 held around the state last November and December, with more than 4,500 physicians attending. Also presenting at the seminars was Harold Whittington, a Dallas-based consultant on medical payment issues, and William A. Godfrey Jr, MD, Blue Cross' Medicare medical director.

State proposes Medicaid RBRVS payment system

THE TEXAS DEPARTMENT of Human Services has proposed changing its system of physician payments to a resource based relative value scale based essentially on the Medicare RBRVS system.

A public hearing was scheduled in early January on the proposed new rules. The Texas Department of Health's Physician Payment Advisory Committee met in mid-December to discuss the proposed regulations, according to Mike Dabbs, TMA director of quality assurance/utilization review. TMA supports this change but will closely monitor its development and implementation, said Mr Dabbs.

Medicaid has proposed paying above the Medicare fee schedule for certain neonatal care, obstetric, and sterilization procedures that were not addressed or were undervalued by Medicare.

TMA's Physician Payment Advisory Committee is continuing to review the fee schedule and receive input from specialty societies. The proposed fee schedule would significantly increase payments for primary care services while reducing overall expenditures for procedures such as laboratory, radiology, and surgery. (See table below.)

The major differences from the Medicare RVRBS system include: no volume performance standards, no geographic practice cost index, a proposed conversion factor of $26.87, and an ongoing system for evaluating access to care to allow for fee adjustments.

Examples of Medicaid fees under the new proposed fee schedule.

Code	Description	Current Payment ($)	Proposed Payment ($)
59420-NP	Initial prenatal visit	16.89	69.00
59420	Subsequent prenatal visit	16.89	22.80
59410	Vaginal delivery	685.17	700.00
90050	Established patient, limited office visit	16.83	26.87
90250	Subsequent hospital visit, limited	29.67	29.13
12001	Repair superficial wound	34.00	45.00
58120	Dilation and curettage	200.00	164.00
42820	Tonsillectomy/adenoidectomy	323.00	176.00

TMA offers guide to new CPT coding system

CHANGES IN THE CURRENT Procedural Terminology (CPT) codes are having a major impact on the way physicians and their staffs handle billing. To simplify the process, TMA is offering a publication entitled *The Coding Tree: Using the New Evaluation and Management Codes*, which uses a series of flowcharts to explain the system.

"This book is a quick reference and training guide to the new codes that will help any physician or office manager to understand the system," said David Marcus, PhD, TMA's director of health-care financing. "It takes you step-by-step through the process of determining the correct code for visits and consultations."

The publication is available to TMA members for $49, including tax and shipping. The nonmember price is $98, including tax and shipping. To order your copy, send a check to Medicare Coding Tree, Texas Medical Association, 401 W 15th St, Austin, TX 78701, or use the order form on page 81.

Placement service puts physicians, practice opportunities together

WHERE DO YOU FIND A doctor when you really need one? For practices and hospitals seeking to add a physician to their staff, it may be as simple as a phone call to the Texas Physician Placement Service.

The computerized service is a joint program of the Texas Medical Association and the Texas Academy of Family Practice (TAFP) that matches physicians and practice opportunities.

The service is free for a physician looking for a practice. The program offers a cost-effective service for hospitals and group practices seeking a physician. A TMA or TAFP member listing a practice opportunity pays $250 for an initial listing, $200 each for additional listings, and $500 upon the hiring of a physician located through the service.

"This makes it possible to recruit a physician for $750," said Mildred Bell, TMA's coordinator of the placement service. "That's quite a bargain when you consider that executive placement services often charge $20,000 or more to find a physician."

Nonmembers may also list practice opportunities with the service, but at a higher fee. Executive search firms are not allowed to use the service.

The service analyzes a physician's background, specialty, and geographic and financial preferences. It also looks at personal considerations such as the size of the community preferred, availability of cultural and recreational activities, and employment opportunities for the physician's spouse.

For a practice opportunity, the service analyzes the location of the opportunity, qualifications needed, type of practice (solo, partnership, HMO, etc), type of services the physician would be performing, and financial arrangements and incentives. In addition, it looks at the demographics of the area, studying cultural, recreational, and other assets of the community.

The data base is updated monthly, with physicians polled about their continuing availability. The service uses several sources to develop demographic data on communities around the state.

According to Ms Bell, location is a high priority in the matching process.

"The majority of physicians registering prefer urban areas like Dallas, Houston, San Antonio, and Austin," she said. "Also, the spouse's career definitely influences the future practice location."

Separate TMA and TAFP programs were merged in 1989 to create the current service, replacing a bimonthly bulletin published by TMA and expanding the computerized service offered by TAFP.

For more information on the Texas Physician Placement Program, contact Mildred Bell at 401 W 15th St, Austin TX, 78701, (800) 880-1300 or (512) 370-1403. ★

TEXAS MEDICINE TO TAKE IN-DEPTH LOOK AT RBRVS

HOW MUCH DOES MEDICARE PAY? Simply calculate this: [{RVUws x GPCIwa} + {RVUpes x GPCIpea} + {RVUms x GPCIma}] x CF = payment.

Confused? You are not alone.

The federal government's Resource Based Relative Value Scale payment system is reality. Time will tell whether it is a brilliant strategy or a bureaucratic boondoggle. The more immediate concern for physicians is how to cope with the dramatic changes it may make in how they practice medicine.

In its March issue, *Texas Medicine* will take an in-depth look at the new payment system and how it affects Texas physicians.

We will look at how the final rules affect practices in different areas of the state and how different specialties fared in the overall payment schedule. We also will examine how the RBRVS system affects health-care financing, practice management, health-care delivery, and risk management, and we will take a look ahead to what TMA and AMA are planning to improve the system.

TMA HASSLE FACTOR LOG

Physician or clinic name _____ **Date** _____

Contact person _____ **Title** _____

Address _____ **Phone number** _____

Company/individual/agency causing hassle _____

Brief description of hassle _____

_____

_____

_____

_____

Is this the first time this problem has occurred or is it a recurring problem? ☐ First Time ☐ Recurring Problem

Subject of hassle:

- ☐ Medical necessity review
- ☐ Quality review
- ☐ Length of stay dispute
- ☐ Precertification of services
- ☐ Referral
- ☐ Problem with terms of HMO/PPO contract
- ☐ Request for information about a patient
- ☐ Denial of payment
- ☐ Reduction of billed charges
- ☐ Recoding of services
- ☐ Other _____

Did this hassle cause the physician or staff to take any of the following actions?

- ☐ Make telephone call(s) How many? _____ Time spent on phone_____
- ☐ Write letter and/or narrative report
- ☐ Resubmit claims
- ☐ Seek outside assistance. If so, from whom?_____
- ☐ Retrieve and review office medical records
- ☐ Retrieve and review hospital medical records
- ☐ Copy and send medical records, progress notes or operative report(s)
- ☐ Consult with colleagues

Can you estimate the total time involved in dealing with this hassle? Staff time _____ Physician time _____

May TMA contact you for additional information? ☐ Yes ☐ No

Please add any additional information you think would be helpful in documenting the nature of this hassle and/or its impact on your medical practice.

_____

_____

_____

_____

Return completed form to TMA Department of Health Care Financing, 401 W 15th St, Austin, TX 78701.

An important review of *Drug Evaluations:*

"...Neither of these books [PDR and USP DI] quite fills the same niche as AMA DE. Although all three are authoritative, the all-star cast of several hundred consultants for AMA DE would be difficult to match. If one were to settle on a single volume, it would be AMA DE."

—Leo E. Hollister, MD, The University of Texas Medical School, Houston
JAMA, Volume 266, July 17, 1991, p. 424
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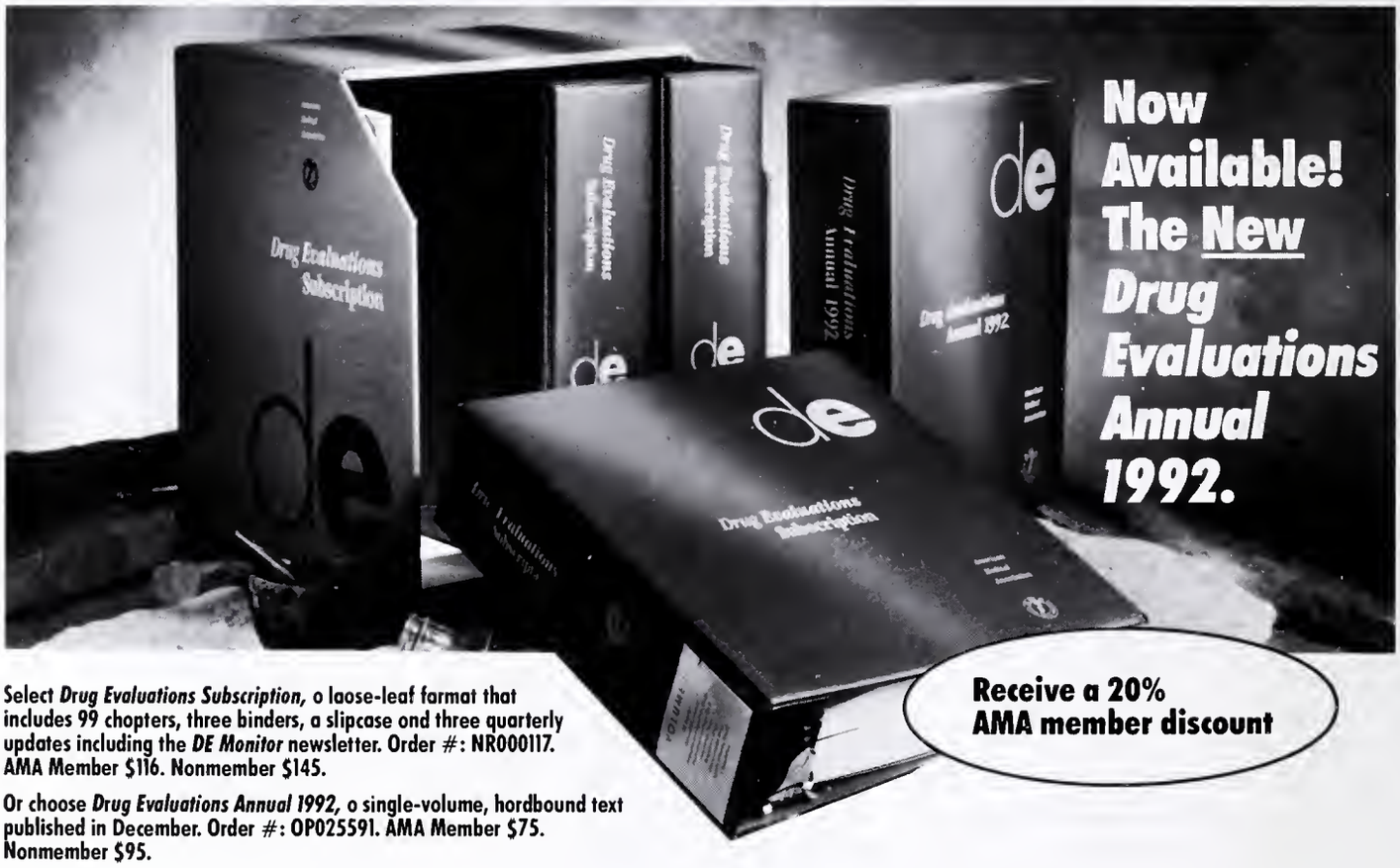

Select *Drug Evaluations Subscription*, a loose-leaf format that includes 99 chapters, three binders, a slipcase and three quarterly updates including the *DE Monitor* newsletter. Order #: NR000117. AMA Member $116. Nonmember $145.

Or choose *Drug Evaluations Annual 1992*, a single-volume, hardbound text published in December. Order #: OP025591. AMA Member $75. Nonmember $95.

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SAN ANTONIO

Texas Medical Association ◆ 125th Annual Session ◆ May 14-17, 1992

Register by April 22
and be eligible to win SPECIAL PRIZES!

NO GENERAL REGISTRATION FEE FOR TMA MEMBERS

For more details, watch for the
ADVANCE PROGRAM in Mid-February!

To register NOW, turn page

1992 Annual Session Advance Registration Form

member ID#

name (please print) (see mailing label)

address specialty

city state zip

Is San Antonio your first session? ☐ yes ☐ no
Did you attend the 1991 Dallas session? ☐ yes ☐ no

MEMBER	No Fee
please check all applicable spaces below:	
☐ Physician	☐ Speaker
☐ Intern/Resident/Fellow	☐ Scientific Exhibitor
☐ Medical Student	☐ 50 Year Club
☐ TMA Officer	☐ HMSS Representative
☐ TMA Delegate	☐ TEXPAC
☐ TMA Alternate Delegate	☐ TEXPAC 300 Club
☐ TMA Councilor	☐ MSS Executive Council
☐ TMA Vice Councilor	☐ MSS Chapter Officer
☐ TMA Board Member ☐ Chairman	☐ MSS Chairman
☐ TMA Council Member ☐ Chairman	☐ RPS Executive Council
☐ TMA Committee Member ☐ Chairman	☐ RPS Chairman
☐ TMA Trustee	☐ RPS Councilor
☐ AMA Member	☐ YPS Chairman
☐ AMA Delegate	☐ YPS Governing Board
☐ AMA Alternate Delegate	☐ CMS Officer

NONMEMBER	Fee
☐ Speaker	waived
☐ TMA Member's Family (attach names)	waived
☐ County Medical Society Staff and Family (attach names)	waived
☐ Physician	$100
☐ Intern, Resident, Fellow	$10
☐ Medical Student	$10
☐ Allied Health Personnel	$10
☐ Approved Visitor	$50
☐ **Nonmember's Family (over age 21)**	$10

Register by April 22 and hav your name entered in the following drawings:

Weekend for Two
Marriott Riverwalk

Luncheon Ticket (Saturday)
Annual Membership Lunche

Brunch for Two (Sunday)
La Mansion del Rio

Tickets for Two
(TMA/TMAA Social Event)
A Night in Old San Antonio
(Friday)

One night for Two
Hilton Palacio del Rio

One night for Two
Marriott Rivercenter

$25 Gift Certificate (Two)
Little Rhine Steakhouse

Advance Ticket Reservation Form

Return completed form with check or credit card information. Pick up tickets at the registration area by 2 pm of previous day of ever

Number Tickets		Amount Enclosed
_____	**A Night in Old San Antonio** Maverick Plaza–La Villita Friday, May 15, 7–11 pm $32 per person/$12.50 children under 12	_____
_____	**Annual Membership Luncheon** San Antonio Convention Center A Celebration of America's 500th Anniversary; Installation of TMA President Saturday, May 16, 12:15–2:15 pm $25 per person	_____
Indicate# _____	**Welcome Fiesta** River Court, San Antonio Convention Center Thursday, May 14, 5–6:30 pm	**No Charge**
	TOTAL	$ _____

name phone #

address

city state zip

Ticket reservation form and payment must be receive by April 22. No refunds after April 29.

Charge to my _____ Visa _____ MasterCard Amount $_____

Acct. No. _____ Exp. Date _____

Name on Card _____

Signature _____

Final Program Order Form

Program will be available mid-April.
For an advance copy return form with $6

name

address

city state zip

Send all forms and any fees to: Texas Medical Associatio
Annual Session and Meeting Management Department
401 West 15th Street
Austin, TX 78701-1680

SAN ANTONIO

Make Your Reservations Now!

Headquarters Hotels and Other Facilities

Requests will be processed first-come, first-served by the Housing Bureau, San Antonio Convention & Visitors Bureau. Hotels will not accept reservations directly, and telephone or fax requests cannot be accepted.

SAN ANTONIO

Texas Medical Association ◆ 125th Annual Session ◆ May 14-17, 1992

Complete the Official Housing Request Form and return immediately to:

TMA Housing
PO Box 2277
San Antonio, TX 78298

Do not send housing form to Texas Medical Association. This will only delay your request.

List six hotels in order of preference.

Confirmations

Acknowledgement of form will be sent within one week to you directly from the Housing Bureau. Confirmation of reservation will follow from hotel within three weeks.

Room Deposits

Send deposit amount indicated on the confirmation form directly to the hotel within 15 days of receipt of confirmation. If a credit card number has been given, a deposit is not required.

Cancellations, Changes and Corrections

All cancellations/changes/corrections prior to April 14 should be made directly with the Housing Bureau **in writing**. After April 14, please contact the assigned hotel directly with any revisions.

Notice of cancellation must be received by hotel within 72 hours of your scheduled arrival to receive deposit refund.

Don't be a no show!

Participating Hotels and Codes

Deadline for Reservations--April 14

★1 HILTON PALACIO DEL RIO (HPR) Headquarters for Scientific Program Participants
200 South Alamo
$101 Single $122 Double

★2 HYATT REGENCY SAN ANTONIO (HYR)
Headquarters for Texas Medical Association Auxiliary
123 Losoya
$95 Single $105 Double

3 LA MANSION DEL RIO (LMR)
112 College
$98 Single $108 Double

4 LA QUINTA-CONVENTION CENTER (LQC)
1001 East Commerce
$68 Single $78 Double

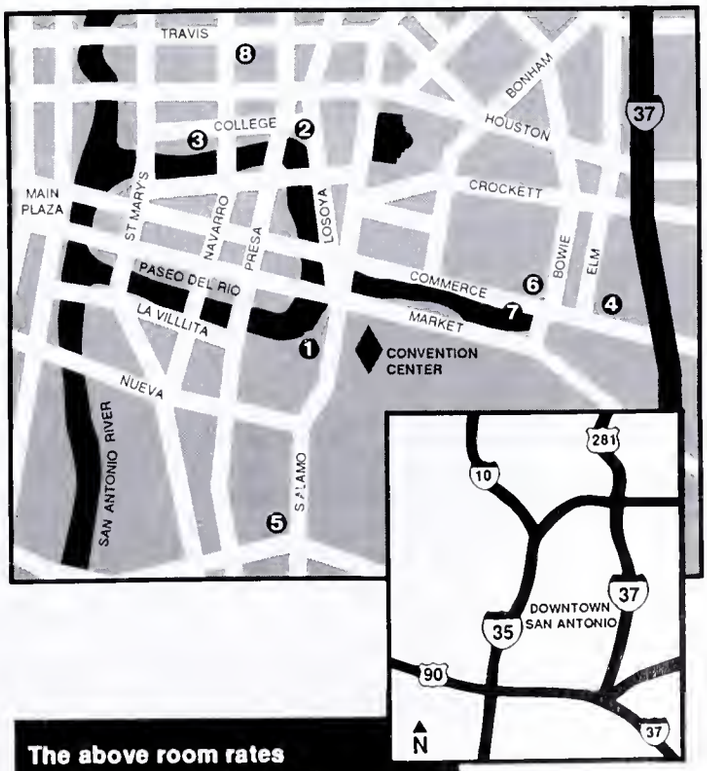
5 PLAZA SAN ANTONIO (PLZ)
555 South Alamo
$98 Single $108 Double

★6 SAN ANTONIO MARRIOTT RIVERCENTER (MRC)
Headquarters for House of Delegates Housing
101 Bowie
$124 Single $140 Double

★7 SAN ANTONIO MARRIOTT RIVERWALK (SAM)
Headquarters for House of Delegates Housing/ Meetings of Boards, Councils, Committees
711 East Riverwalk
$109 Single $125 Double

8 ST. ANTHONY (SAI)
300 East Travis
$79 Single $89 Double

◆ SAN ANTONIO CONVENTION CENTER
Exhibits, Meetings of the House of Delegates and Scientific Sessions
200 East Market



The above room rates do not include 13% hotel occupancy tax.

★ Headquarters Hotels

MAIL TO:

TMA HOUSING
P.O. BOX 2277
SAN ANTONIO, TEXAS 78298

RESERVATION CUTOF
APRIL 14, 199

Texas Medical Association
May 14-17, 1992
OFFICIAL HOUSING REQUEST FORM

TexasMedical Association

- TELEPHONE OR FAX REQUESTS NOT ACCEPTED.
- PLEASE PRINT OR TYPE ALL ITEMS TO ASSURE ACCURACY AND RAPID COMPUTER PROCESSING.
- PHOTOCOPY THIS FORM IF MORE THAN TWO ROOMS ARE REQUIRED, KEEP COPY FOR YOUR FILE.
- ACKNOWLEDGEMENT(S) WILL BE SENT ONLY TO INDIVIDUAL AT ADDRESS GIVEN BELOW.
- ROOM WILL NOT BE SECURED FOR PERSON RECEIVING ACKNOWLEDGEMENT UNLESS LISTED BELOW IN ROOM 1 OR 2.
- HOTEL WILL SEND ACTUAL CONFIRMATION (refer to GUARANTEE LATE ARRIVAL).
- CANCELLATIONS/CHANGES/CORRECTIONS (refer to ACKNOWLEDGEMENT).

(LAST NAME) (FIRST)

(NAME OF COMPANY OR FIRM)

(STREET ADDRESS OR P.O. BOX NUMBER)

(CITY) (STATE) (ZIP—USA)

(COUNTRY) (AREA CODE) (WORK NUMBER)

INSTRUCTIONS: Select SIX Hotels/Motels of your choice. Request will not be processed without SIX choices.
USE CODES ONLY - DO NOT USE NUMBERS - REFER TO HOTEL INFORMATION FOR LETTER CODES

FIRST CHOICE (HOTEL CODE) SECOND CHOICE (HOTEL CODE) THIRD CHOICE (HOTEL CODE)

FOURTH CHOICE (HOTEL CODE) FIFTH CHOICE (HOTEL CODE) SIXTH CHOICE (HOTEL CODE)

GUARANTEE LATE ARRIVAL BY CREDIT CARD. Hotel policies vary. Not all hotels hold rooms until 6 PM or honor all credit cards. Some 1st night deposit. Hotel confirmation will specify policies. Contact hotel directly.

(Name of credit card holder) (Type of card AE, MC, VISA) (Credit card number) (Expiration da

***SPECIAL NOTE:** Rooms are assigned on "First Come/First Serve" basis AND room availability for your arrival/departure. Rooms required 2 or post or pre convention are not always available through the housing bureau. The acknowledgement will advise you to call the hotel direct for additi (not always available at convention rate). If none of the choices listed are available, another facility will be assigned based on a referral system dete your association.

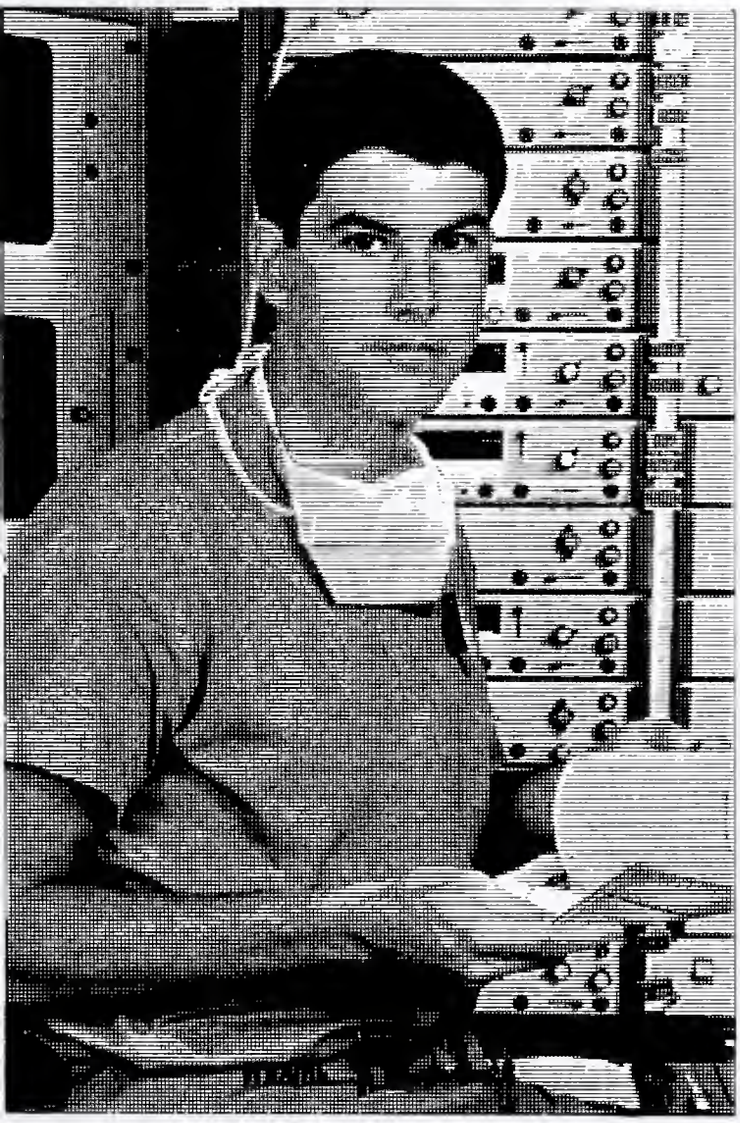
ROOM 1

DO NOT DUPLICATE - If sharing room(s) designate ONE person to send request OCCUPANT(S) PRINT - LAST NAME FIRST	BUREAU will assign convention dates if arrival/departure are not given. * See Special Note	SELECT TYPE ROOM DESIRED	
1.	ARR. DATE _____	____ Single (1 pers., 1 bed)	____ Quad (4 ppl, 2 bed
2.	ARR. TIME _____ ☐ AM ☐ PM	____ Double (2 ppl, 1 bed)	____ P+1 (parlor, 1 bd
3.		____ Dbl/Dbl (2 ppl, 2 beds)	____ P+2 (parlor, 2 bd
4.	DEPART _____	____ Triple (3 ppl, 1-2 beds)	Check here for handicap

ROOM 2

1.	ARR. DATE _____	____ Single (1 pers., 1 bed)	____ Quad (4 ppl, 2 bed
2.	ARR. TIME _____ ☐ AM ☐ PM	____ Double (2 ppl, 1 bed)	____ P+1 (parlor, 1 bd
3.		____ Dbl/Dbl (2 ppl, 2 beds)	____ P+2 (parlor, 2 bd
4.	DEPART _____	____ Triple (3 ppl, 1-2 beds)	Check here for handicap

PHYSICIANS, THERE ARE TWO KINDS OF FLEXIBILITY IN THE ARMY RESERVE WE THINK YOU'LL LIKE.



One, time. We know how tough it is for a busy physician to make weekend time commitments. So we can offer the kind of flexible time scheduling that allows a physician to share sixteen hours a month with his or her country. We can arrange a schedule to suit your requirements.

Two, the opportunity to explore other phases of medicine, to add a different kind of knowledge — the challenge of military health care. It's a flexibility that could prove to be both stimulating and rewarding, with the opportunity to participate in a variety of programs that can put you in contact with medical leaders from all over the country.

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Call Your USAR AMEDD Counselors

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El Paso - Major C. Hacker (915) 532-7190
Houston - Major Joseph Rankin (713) 963-8150
San Antonio - Major John Terry (512) 826-9893

Major Craig Hacker (512) 826-9893

BE ALL YOU CAN BE.
ARMY RESERVE

Public Health

Death certificates provide valuable public health data

How does the information on death certificates benefit public health in Texas? With this first installment, Texas Medicine *begins a report on what data the Texas Department of Health (TDH) gathers from these certificates, the physician's role in completing death certificates, and how to amend the certificates.*

TO SOME IT'S JUST ANOTHER legal form to complete. But to others the information appearing on death certificates is a direct link to curing the public health woes confronting Texans. And physicians play a vital role in ensuring the accuracy of the information.

"From our point of view, aside from the legal function of the [death] certificate, the information gathered is basic public health data," says Gail C. Larimer, branch supervisor, TDH bureau of vital statistics (BVS). "It describes the health status of Texans, and this information can help physicians provide better care for their patients."

A glance at 1990 numbers

A look at the 1990 Texas Vital Statistics Annual Report reveals:

- 125,019 Texans died.
- Total deaths increased by 456 from the previous year.
- HIV infection killed 1,836 people and is now on the top 10 list of killers in the state.
- The leading causes of death were: heart disease (39,443); cancer (28,483); cerebrovascular diseases (8,388); accidents (6,225); chronic obstructive pulmonary diseases and allied conditions (4,857); pneumonia and influenza (4,267); diabetes mellitus (3,458); homicide (2,391); and suicide (2,156).
- Firearms surpassed motor vehicles as the leading cause of injury mortality.

"These figures allow us to determine who is dying, where people are dying, how they are dying, and when they are dying," says Ms Larimer. "The better information we receive, the better data we can provide to the medical research community."

How is the information used?

When information gathered from death certificates is used to determine health trends in Texas, Tom Pollard, director of TDH statistical services division, says it "is like the dead teaching the living."

According to the US Department of Health and Human Services, information gathered from death certificates is used to:

- assess the general health of the population and evaluate the success of medical treatment;
- examine medical problems prevalent among certain population groups;
- indicate areas where medical research can have the greatest impact for promoting health and preventing disease;
- determine major means for identifying public health problems;
- measure program results designed to cure health problems;
- allocate medical and health-care services;
- follow up infant deaths, maternal deaths, and certain infectious diseases;
- identify disease etiology and eva uate diagnostic and therapeut techniques;
- reveal leading causes of deat disease, and injuries;
- develop epidemiological studi in such areas as coronary hea disease and cancer;
- locate geographic areas with el vated death rates from selecte causes of death; and
- measure health status at the loc level.

Who requests the data?

The health department isn't the on group using the information.

The BVS has received requests f statistics on death in Texas from t Centers for Disease Control, Natio al Center for Health Statistics, Soci Security Administration, The Unive sity of Texas Health Science Center Texas Cancer Data Center, Tex Commission on Alcohol and Dru Abuse, Texas State Data Cente Texas Department of Public Safet Consumer Products Safety Commi sion, National Safety Council, Ame ican Red Cross, Texas Pharmac Board, Texas Education Agency, an American Heart Association.

Other requests have come fro local health departments, the oil an gas industry, the chemical industr chambers of commerce, city pla ning departments, researchers, su cide prevention organizations, an Texas legislators.

The data are used by public an private organizations to monit health conditions near toxic was sites, chemical plants, and other are where health concerns warrant clos examinations. The safety of consum products also can be determined fro death certificate information.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

AGENDA ON AIDS

Literature available on managing first AIDS patient

Doctors face a tremendous challenge when they begin managing the care of their first HIV-infected patient. The AIDS Regional Education and raining Centers for Texas and Oklahoma (ETC) has available a *Physician's tarter Kit for Your First Adult HIV Patient.*

Items in the kit include: Managing the HIV Infected/AIDS Patient, the merican Medical Association's Physician Guidelines to HIV Early Care, everal articles on care of HIV patients, and a list of selected resources (medical textbooks, handbooks for caregivers and patients, journal articles, pamhlets, national publications, and selected newsletters).

The ETC also has a helpline, (800) 548-4659, to assist with questions nd literature searches in relation to management of HIV-positive patients.

For information on the packet, contact Richard M. Grimes, PhD, director, AIDS Regional Education and Training Centers for Texas and Oklahoma, The University of Texas Health Science Center at Houston, School of Public Health, PO Box 20186, Houston, TX 77225.

Mothers, not fathers, talk more with children about AIDS

Mothers are more likely than fathers to discuss AIDS with their children, according to data from the 1989 National Health Interview survey. The urvey was conducted by the Centers for Disease Control National Center or Health Statistics. The information (*Morbidity and Mortality Weekly Report*, November 22, 1991) was analyzed to determine the characteristics of parents who reported discussing or not discussing AIDS with their 10- to 17-year-old children. The findings included:

- Out of 8,058 parents, 62% said they had discussed AIDS with their children.
- Mothers (74.2%) are more likely to discuss AIDS than fathers (48.9%).
- Non-Hispanics (63.4%) were more likely to discuss AIDS with children than Hispanics (51.7%).
- Parents in metropolitan statistical areas with populations of fewer than 100,000 were more likely to talk about AIDS with their children than parents in larger cities.

Elderly driver program aims to educate physicians

IN HOPES OF MAKING THE state's highways a safer place, the Texas Department of Health (TDH) and a Texas Medical Association focus group have joined forces to educate physicians about elderly drivers.

With the help of federal funding for one year, the TDH public health promotion division is developing a booklet designed to help physicians address the needs of elderly patients who also operate motor vehicles.

"There hasn't been a lot done with physicians in this area of aging and driving," says Carla Baker, TDH statewide coordinator for Mature Driver Education Programs.

Members of the focus group, which includes physicians, a behavioral psychologist, representatives from Texas Department of Public Safety (DPS), Texas Department of Transportation, and TDH along with TMA personnel, met recently to discuss what information should be included in a brochure that targets doctors and their older patients.

"Doctors don't always realize that the older patient is driving a car," says Otto Lippman, MD, Austin, a focus group member.

Items considered and reviewed for the brochure by the group included:

- the physician's role in determining an elderly patient's ability to operate a motor vehicle;
- gaining assistance from DPS and the TDH medical advisory board to determine ability to drive and to retain a license;
- developing a medication chart to illustrate drugs' effect on patients' ability to drive;
- methods to test older drivers for license renewal;
- psychological aspects of losing a license based on inability to drive due to age;
- patients who neglect medical treatment due to fear they might have their licenses suspended;
- ways to assist patients who are at impending risk if they drive;
- liability of physician who suggests patient should not drive; and
- availability of education programs offered by the state.

The brochure is expected to be completed by March and distributed on a trial basis through the Harris County Medical Society. Statewide distribution will be based on response to the pilot program.

Vehicular and pedestrian deaths and injuries among Texans, ages 55 and up, in 1990.
Source: Texas Department of Public Safety.

	Age		
Categories	**55-64**	**65-74**	**75+**
Number of drivers involved in all collisions*	**40,945**	**28,023**	**16,769**
Number of drivers involved in fatal collisions*	**259**	**184**	**165**
Vehicular deaths*	**165**	**151**	**163**
Vehicular injuries*	**12,936**	**8,891**	**5,329**
Pedestrian and pedicyclist deaths	**57**	**29**	**38**
Pedestrian and pedicyclist injuries	**167**	**130**	**98**

** Does not include pedestrians and pedicyclists*

COMMENTARY

Vaccinations: it's time to improve the record

Suzanne Corrigan, MD
Texas Pediatric Society, a Chapter of the American Academy of Pediatrics

THERE IS A CLEAR SIGNAL that the children of Texas are not getting the health care they need: 50% of Texas preschoolers are not adequately immunized against diseases, such as measles, polio, and whooping cough. Even more disturbing and tragic is that in 1989 and 1990, measles — a preventable disease — claimed the lives of 22 individuals.

The counties of Dallas and Harris were hit particularly hard. Ten of the 12 measles deaths in 1990 occurred in Dallas County and 8 of the 10 deaths in 1989 occurred in Harris County. Counties confirming between 100 to 500 cases were El Paso, Lubbock, Travis, Tarrant, Denton, and Bexar. Mexican border counties, which include Webb, Cameron, and Hildago, also reported high incidences of measles. The greatest number of cases occurred in children younger than 4 years old.

Immunizations are the single most cost-effective procedure to protect against potentially life-threatening diseases. For every $1 spent on vaccine, $10 is saved in future health-care costs. Inadequate funding, lack of public awareness, and lack of access to health care are hampering the delivery of vaccines.

As physicians, we also are part of the problem because we miss opportunities to immunize our patients. The American Academy of Pediatrics and The Children's Action Network have taken steps to publicize this problem through the cosponsorship of National Immunization Week. The event, held in September, is a major national effort to fight these epidemics, help save lives, and preserve health-care dollars.

The following suggestions will help solve the problems surrounding immunization of children:

- Check immunization records on each child treated, whether sick or well. Update all the child shots during one visit.
- Offer "shots only" appointment at convenient times for those pa tients who don't have the mone to pay for an office visit.
- Provide parents with an immu nization schedule.
- Stay alert to changes released b the American Academy of Pedi atrics and Centers for Diseas Control on immunizations.

American Academy of Pediatrics recommendations for routine immunizations, revised March 1991.

	DPT	Polio	Measles	Mumps	Rubella	Haemophilus‡	Tetanus-Diphtheria
2 months	✔	✔				✔	
4 months	✔	✔				✔	
6 months	✔		✔†			(✔)	
12–15 months						(✔)	
15 months			✔	✔	✔	(✔)	
15–18 months	✔	✔					
4–6 years	✔	✔					
11–12 years*			✔	✔	✔		
14–16 years							✔

* *Except where public health authorities require otherwise.*

† *The Centers for Disease Control, American Academy of Pediatrics, and the Texas Department of Health recommend a measles vaccination at 6 months for infants in epidemic settings.*

‡ *As of March 1991, two vacines for* Haemophilus influenzae *infections have been approved for use in children younger than 15 months of age.*

( ) *Indicated in many circumstances depending on which vaccine for* Haemophilus influenzae *infections was previously given.*

COMMENTARY

Take note: HBV is serious threat

Richard M. Grimes, PhD
Director, AIDS Regional Education and Training Centers for Texas and Oklahoma, The University of Texas Health Science Center at Houston, School of Public Health

LAST JUNE MARKED THE EN of the 10th year since the firs AIDS cases were reported. B 1987, the transmission of huma immunodeficiency virus (HIV) t health-care workers had been docu mented. Therefore, the Centers fo Disease Control issued guidelines fo the prevention of transmission o HIV and hepatitis B virus (HBV) The inclusion of hepatitis B sur prised many health-care workers However, as the table on the follow ing page shows, patient-transmitte HBV poses a far more serious threa to health-care workers than does HIV. Health-care workers who are not immunized against HBV shoul take particular note.

[Editor's note: New regulations from the Occupational Safety and Health Administration (OSHA) governing hepatitis B vaccinations are discussed on p 28.]

MEDICAL STUDENTS MUST HAVE HBV IMMUNIZATION

EFFECTIVE JANUARY 1, 1992, all medical and dental students, along with residents and interns, must be inoculated with the hepatitis B vaccine or show serologic immunity prior to the start of direct patient care, according to the Texas Department of Health.

The regulation, under Section 2.09 of the Texas Education Code, also encourages all students enrolled in health-related courses (not just those involved in direct patient care) to receive the complete series of hepatitis B vaccine. Students who have not been completely immunized with the hepatitis B vaccine should complete the series as quickly as medically feasible.

The vaccine is available from SmithKline Beecham Pharmaceuticals (Engerix-B) or Merck Sharp & Dohme (Recombivax HB).

Comparison of HIV and HBV in US health-care workers, 1981-1991.

	HBV (1)	HIV (2)
Infections	120,000[a]	< 700[b]
Diagnosed cases	30,000[a]	< 70[b]
Self-limited, subclinical cases	90,000[a]	presumed to be 0
Deaths	120-150[a]	< 10[c]
Carriers of virus	7,000-12,000[a]	< 600[b]
Expected deaths in carriers	2,100-2,500[a]	all

[a] *CDC annual estimates multiplied by 10 years.*

[b] *CDC reports a total of 70 health-care workers with AIDS for whom no other risk has been identified. This was multiplied by 10 to reflect the usual estimate of 10 HIV infected for each diagnosed AIDS case. However, investigation is incomplete in many of the 70 cases so the final number is expected to be less than 700. As of March 1991, there were 24 confirmed occupationally related seroconversions, 3 of which are diagnosed AIDS cases (personal communication, Centers for Disease Control, March 13, 1991).*

[c] *Some infected health-care workers refused CDC interviews or died prior to interview so an exact number cannot be determined. It probably would be less than 10.*

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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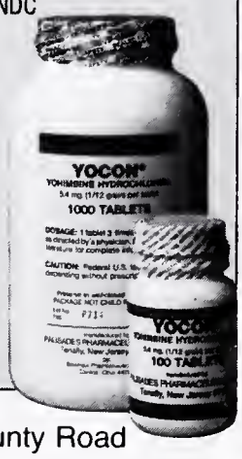

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

The intractable pain treatment act of Texas

C. Stratton Hill, Jr, MD

There is overwhelming evidence that all types of pain, either of malignant or nonmalignant origin, are undertreated. This is especially true of patients whose pain can only be relieved by strong narcotics. The disciplinary section of the Texas Medical Practice Act (MPA) contains ambiguous language that makes determining proper standards for the use of narcotics difficult. To clarify this, the Intractable Pain Treatment Act (IPTA) allows the use of narcotics to treat intractable pain, without regard to the etiology of the pain, and clarifies narcotic use standards by defining intractable pain. The IPTA brings Texas law more into conformity with federal law, which clearly states that narcotics have a proper place in the treatment of intractable pain even if the etiology is not established. Reluctance to use narcotics for selected patients with nonmalignant painful medical conditions stems from the mistaken belief that they will become narcotic "addicts." Data from the medical literature do not support such a contention; in fact, just the opposite is supported.

Send reprint requests to Dr Hill, Department of Neuro-Oncology, The University of Texas M.D. Anderson Cancer Center, 1515 Holcombe Blvd, Houston, TX 77030.

The 71st Session of the Texas Legislature passed Senate Bill 20, The Intractable Pain Treatment Act (IPTA) (1), in the first called session in July 1989; the act became effective November 1, 1989. The intents of the Texas legislature were to clarify language in the Medical Practice Act of Texas (MPA)(2) about prescribing controlled drugs (narcotics) for pain and to assure that no Texan requiring narcotics for pain relief, for whatever reason, was denied them because of a physician's real or perceived fear that the state regulatory agency would take disciplinary measures against the physician for prescribing narcotics to relieve pain.

The MPA is the statute that establishes the Texas State Board of Medical Examiners (BME) as the official agency to examine and license physicians for the practice of medicine. Further, this agency regulates the practice of medicine in the state and disciplines physicians who are judged to be in violation of the act or whose practice is judged to be at unacceptable variance with or below acceptable medical practice standards.

The need for the IPTA stemmed from the ambiguous language regarding narcotic prescribing contained in Section 3.08(4)(C) of the MPA. (See *Medical Practice Act of Texas and Other Statutes Relating to Physicians*, a publication of the Texas State Board of Medical Examiners, for literal language of this section.) This section states that a physician (licensee of the board) may lose his or her license if narcotics are prescribed to a "habitual user" or to a person the physician "should have known" was a habitual user of them. The MPA neither defines "habitual user" (street jargon implying a drug abuser) nor distinguishes a person taking these drugs for legitimate medical purposes from a person taking them for nonmedical reasons (a drug abuser).

ESSENTIAL FEATURES OF THE ACT

The IPTA states positively that narcotics can be used for the legitimate medical purpose of relieving intractable pain from whatever cause and, by defining intractable pain, sets a new guideline for determining the standard of medical practice applied to use of narcotics in controlling pain. Specifically, the act defines intractable pain; authorizes use of narcotics by a physician to treat intractable pain, from either nonmalignant or malignant causes, even if reasonable efforts fail to establish an etiology or treatable cause for it; prohibits administrative authorities of hospitals or other health-care facilities from interfering with the physician who uses these drugs for the treatment of intractable pain; and prohibits the BME from disciplining a physician who uses these drugs for treating intractable pain.

The law reiterates, however, that the control over the mechanism of prescribing narcotics remains the same and that all rules and regulations designed to prevent diversion of legal drugs to illegal purposes remain intact.

RELATIONSHIP OF STATE LAW TO FEDERAL LAW

The IPTA brings Texas law more into conformity with federal law that regulates the use of narcotics. Title 21, Section 1306.07(C) of the Code of Federal Regulations states, "This section is not intended to impose any limitations on a physician or authorized hospital staff . . . to administer or dispense narcotic

rugs to persons with intractable ain in which no relief or cure is ossible or none has been found af- r reasonable efforts" (3). The Drug nforcement Administration's Physi- ian's Manual further explains this ection: "Controlled substances and, n particular, narcotic analgesics, nay be used in the treatment of pain xperienced by a patient with a ter- ninal illness or chronic disorder. These drugs have a legitimate clini- al use and the physician should not iesitate to prescribe, dispense, or dminister them when they are indi- ated for a legitimate medical pur- ose. It is the position of the Drug Enforcement Administration that hese controlled substances should e prescribed, dispensed, or admin- stered when there is a legitimate nedical need" (4).

THE IPTA, TREATMENT FOR PAIN, AND STANDARDS OF MEDICAL PRACTICE

Section 2(3) of the IPTA defines intractable pain as ". . . a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts" (1). Upon making a diagnosis of intractable pain, a physician may prescribe a narcotic if a narcotic is required to relieve the pain. The etiology of the pain is not pertinent; therefore, nonmalignant and malignant intractable pain can be treated with a narcotic if such a drug is required.

Use of narcotics to treat pain defined in this way presents a challenge to the medical practice standard of customary usage. Presently, the customary usage of narcotics in the community, based on a case-by-case determination, consists of prescribing inadequate doses for almost all painful conditions, both acute and chronic (5–11); and not using narcotics for treatment of nonmalignant chronic, intractable medical conditions.

Underdosing for all chronic painful illnesses and failure to relieve pain in chronic, intractable nonmalignant painful conditions if narcotics are required is, therefore, the accepted standard for medical practice. The IPTA allows for the adequate treatment of these conditions, including the use of narcotics, thereby setting a new standard.

The MPA standard that the IPTA challenges most is Section 3.08(4)(E), which forbids "prescribing or administering a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered" (12). Obviously, such a phrase requires interpretation of what is "nontherapeutic." The interpretation of such a vague and imprecise term in a statute governing standards for medical practice regarding use of narcotics must be based on rational and unbiased knowledge about opiate use and its consequences. Modern knowledge of narcotic pharmacology and concepts about the nature of pain must be used to judge treatment outcome. Other reasonable considerations in interpreting this term should include not causing the patient to suffer needless pain and not punishing the physician (in the name of discipline for "substandard" medical practice) for providing humane and compassionate care. If customary (undertreatment) community practices, perpetuated by enforcement practices of the BME, are used to interpret this section of the MPA, the use of narcotics for the treatment of intractable pain in nonmalignant conditions such as osteoporosis, certain types of chronic back pain, various forms of arthritis, frequent vascular headaches, or so-called "failed backs" would never be acceptable practice, notwithstanding that relieving the patient's pain may be impossible without them. If physicians adhered to this standard, their patients and their families would be doomed to a life of unmitigated misery and suffering. Fortunately, despite the current interpretation of the standard, most physicians faced with this dilemma and for humane reasons prescribe narcotics for patients suffering these conditions, recognizing that otherwise their patients would suffer needlessly (13).

The prime reason for reluctance to use narcotics for these types of conditions is that patients requiring narcotics for relief of such conditions are invariably labeled as "drug addicts" or "drug abusers" because society fails to distinguish between the drug abuser and the patient who requires these drugs for their recognized pharmacological indication. Data from the medical literature on patients requiring long-term narcotic use for medical purposes, including nonmalignant painful medical conditions, do not support the belief that these patients invariably become drug abusers; in fact, the data support the opposite view. (14,15). That drug abuse is socially unacceptable behavior is agreed universally; its prevention certainly protects the public health and welfare from its socially undesirable consequences. Patients who take narcotics for a legitimate medical purpose are not drug abusers; therefore, they do not pose a threat to the public health and welfare, and physicians

who prescribe narcotics for them are neither creating a threat to public health nor practicing medicine below the accepted standard. Unfortunately, our society fails almost invariably to make the distinction between legitimate and illegitimate use of narcotics. As a result, narcotics become societally or culturally "nontherapeutic," though they are not pharmacologically nontherapeutic; certainly, prescribing an analgesic for pain relief is pharmacologically therapeutic. Fortunately, rational use of narcotics for treatment of nonmalignant chronic conditions characterized by intractable pain is gaining greater acceptance (16–19). Using the Texas IPTA as a model, the state of California recently passed the California Intractable Pain Treatment Act (20).

SUMMARY

The IPTA, by defining intractable pain, sets a new standard that allows a physician who diagnoses intractable pain to use narcotics if indicated to provide relief, regardless of the cause of the pain. The assurance that using narcotics for relief of pain is permissible under the provision of this act should encourage physicians to use narcotics to relieve pain when necessary without fear of disciplinary action by the BME.

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The use of mechanical ventilation via a nasal mask in myotonic dystrophy

Amal Jubran, MD
Gilbert E. D'Alonzo, DO
Martin J. Tobin, MD

36-year-old woman with myotonic 'strophy presented with generalized eakness and daytime somnolence. 'terial blood gas analysis revealed gnificant hypoxemia and hypercap- a, and a polysomnogram revealed lditional oxygen desaturation dur- g sleep. For nocturnal ventilatory sistance, the patient received posi- ve-pressure ventilation via a nasal ask. This mode of ventilation pro- ced marked improvement in the tient's nocturnal hypoxemia.

Drs Jubran and Tobin, Division of Pulmonary and Critical Care Medicine, Edward Hines Jr Veterans Administration Hospital, Loyola University of Chicago Stritch School of Medicine, Hines, Ill. Dr D'Alonzo, Division of Pulmonary and Critical Care Medicine, The University of Texas Health Science Center at Houston. Send reprint requests to Dr Jubran, Division of Pulmonary and Critical Care Medicine, Edward Hines Jr Veterans Administration Hospital, Route 111N, Loyola University of Chicago Stritch School of Medicine, Hines, IL 60141.

Myotonic dystrophy is an autosomal dominant disorder that affects skeletal muscles — in particular, respiratory muscles — and leads to early ventilatory failure and premature death (1). A characteristic feature is an aggravation of respiratory insufficiency during sleep. This nocturnal hypoventilation has been conventionally managed by mechanical ventilation. To avoid the need for tracheostomy, negative-pressure ventilators, such as a body wrap or a cuirass ventilator, were employed initially; however, these ventilators cause or aggravate upper airway obstruction and also cause chest wall discomfort (2). Consequently, positive-pressure ventilators have been used in combination with a tracheostomy. Attempts have been made recently to avoid tracheostomy by delivering positive-pressure ventilation through a nasal mask (3,4). We report the successful use of such a therapeutic approach in a patient with myotonic dystrophy.

CASE REPORT

A 36-year-old woman with myotonic dystrophy that had been diagnosed in 1981 presented to Hermann Hospital, Houston, with a history of progressive weakness, dyspnea, restless sleep, and daytime hypersomnolence. During physical examination, she was lethargic; vital signs were stable except for a respiratory rate of 34 breaths/min. Diffuse facial weakness with wasting of the temporal muscles was evident. Pulmonary auscultation revealed bibasilar crackles, and cardiac examination was normal. The neurological examination revealed mild weakness in all extremities without any sensory deficits. Grip myotonia as well as percussion myotonia of the thenar muscles could be elicited.

Measurements of blood gases while the patient was breathing room air revealed an arterial oxygen tension (PaO_2) of 49 mm Hg, an arterial carbon dioxide tension ($PaCO_2$) of 56 mm Hg, and a pH of 7.33. Repeat measurements while she was inhaling 30% oxygen through a face mask showed a PaO_2 of 60 mm Hg, a $PaCO_2$ of 66 mm Hg, and a pH of 7.32. A chest radiograph showed bibasilar subsegmental atelectasis. Pulmonary function tests showed a severely reduced vital capacity of 0.85 L (29% of predicted normal value), a total lung capacity of 2.43 L (66% of predicted), and a normal residual volume, 1.55 L (96% of predicted). Maximal inspiratory mouth pressure was 16 cm H_2O (normal=87±32 cm H_2O) (5) and maximal expiratory mouth pressure was 22 cm H_2O (normal=152±54 cm H_2O) (5). The ventilatory response to hypercapnia was assessed during CO_2 rebreathing, and the slope of the response was markedly decreased, with 0.4 L/min per end-tidal CO_2 concentration expressed as a percent. Normal values are 1.2 to 6.2 L/min per end-tidal CO_2 concentration expressed as a percent (6).

An all-night polysomnogram was performed while the patient was breathing room air. This study showed repeated episodes of severe hypopnea but no significant apneas. These episodes were associated with periods of desaturation with an average arterial oxyhemoglobin saturation (SaO_2) of 87% and a minimum SaO_2 of 74%. A repeat study performed while the patient received supplemental oxygen (2 L/min via nasal cannula) revealed repeated episodes of desaturation with an average SaO_2 of 62% and a minimum SaO_2 of 40%.

Fig 1. Portable mechanical ventilator delivered positive-pressure ventilation to patient using a tight-fitting nasal mask.

A third polysomnogram was performed while intermittent positive-pressure ventilation was delivered via a nasal mask. The mask was made of flexible plastic, and adjustment of attached headbands achieved a virtually airtight seal (Respironics, Inc, Monroeville, Pa). This was attached to a volume-cycled portable ventilator (LP-6, Acquitron Medical Inc, Plymouth, Minn), and room air without humidification was delivered (Fig 1). The ventilator was set in the assist control mode, and the sensitivity was such that the patient triggered each inspiration. The delivered tidal volume was set at 1,000 mL. The polysomnogram performed with this device revealed an average Sa_{O_2} of 90%, but there were episodes of desaturation with Sa_{O_2} as low as 75%. These hypopneic episodes were associated with a decrease in oronasal air flow and were obstructive. As a result, a positive end-expiratory pressure (PEEP) valve was attached to the expiratory line in an attempt to decrease these hypopneas. A final study using nasal ventilation and PEEP revealed an average Sa_{O_2} of 92% with occasional episodes of desaturation to slightly below an Sa_{O_2} of 90% (Fig 2). The patient was then treated with this mask-ventilator system on a nightly basis. She noted an immediate improvement in her quality of sleep and daytime hypersomnolence. Two months after initiating nocturnal ventilation, the patient was aware of an increase in her strength and was finally able to perform independently her daily household activities. Measurements of arterial blood gases at 6 months showed a Pa_{O_2} of 69 mm Hg, a PaC_{O_2} of 52 mm Hg, and a pH of 7.34, while pulmonary function tests showed a 10% improvement in vital capacity. In addition, the inspiratory mouth pressure increased to 53 cm H_2O, whereas the expiratory mouth pressure was 25 cm H_2O. The ventilatory response to hypercapnia, following the initiation of positive-pressure ventilation, was 1.4 L/min per end-tidal CO_2 concentration expressed as a percent.

DISCUSSION

This patient with myotonic dystrophy had severe weakness of her respiratory muscles as reflected by the decrease in the maximal mouth pressures, yet her general muscle strength (eg, hand grip) was quite good. Her respiratory muscle weakness was severe enough to cause alveolar hypoventilation, which worsened during sleep. Other factors also may have contributed to her nocturnal hypoventilation. It has been suggested that patients with myotonic dystrophy may have a decreased motor output from the respiratory center; indeed, our patient had a decreased ventilatory response to hypercapnia. While this decreased response may have resulted from a decreased respiratory center output, it may also have been secondary to her abnormal respiratory muscle function or to a combination of both factors (7).

The delivery of nocturnal ventilatory assistance was a major goal in this patient. Negative-pressure ventilation was not attempted because of the potential for complications (8). To circumvent the need for a tracheostomy, intermittent positive-pressure ventilation was delivered through a nasal mask, as has been recently suggested (3,4). The risk of developing upper airway obstruction, especially in view of our patient's severe respiratory muscle weakness, led us to use positive-pressure ventilation. This mode of ventilation decreased her nocturnal desaturation and improved her mental alertness. Also, the increase in the inspiratory mouth pressure indicated an improvement in the strength of her respiratory muscles. Of interest was the fact that the patient required a PEEP valve in addition to intermittent positive-pressure ventilation to achieve a satisfactory arterial oxygen saturation. The PEEP may have a splinting action that stabilized the upper airways and prevented obstructive hypopneas (9). Furthermore, recruitment of lung volume secondary to the application of PEEP may have improved oxygenation. The patient has tolerated the mask well, and she is currently being managed at home with this system.

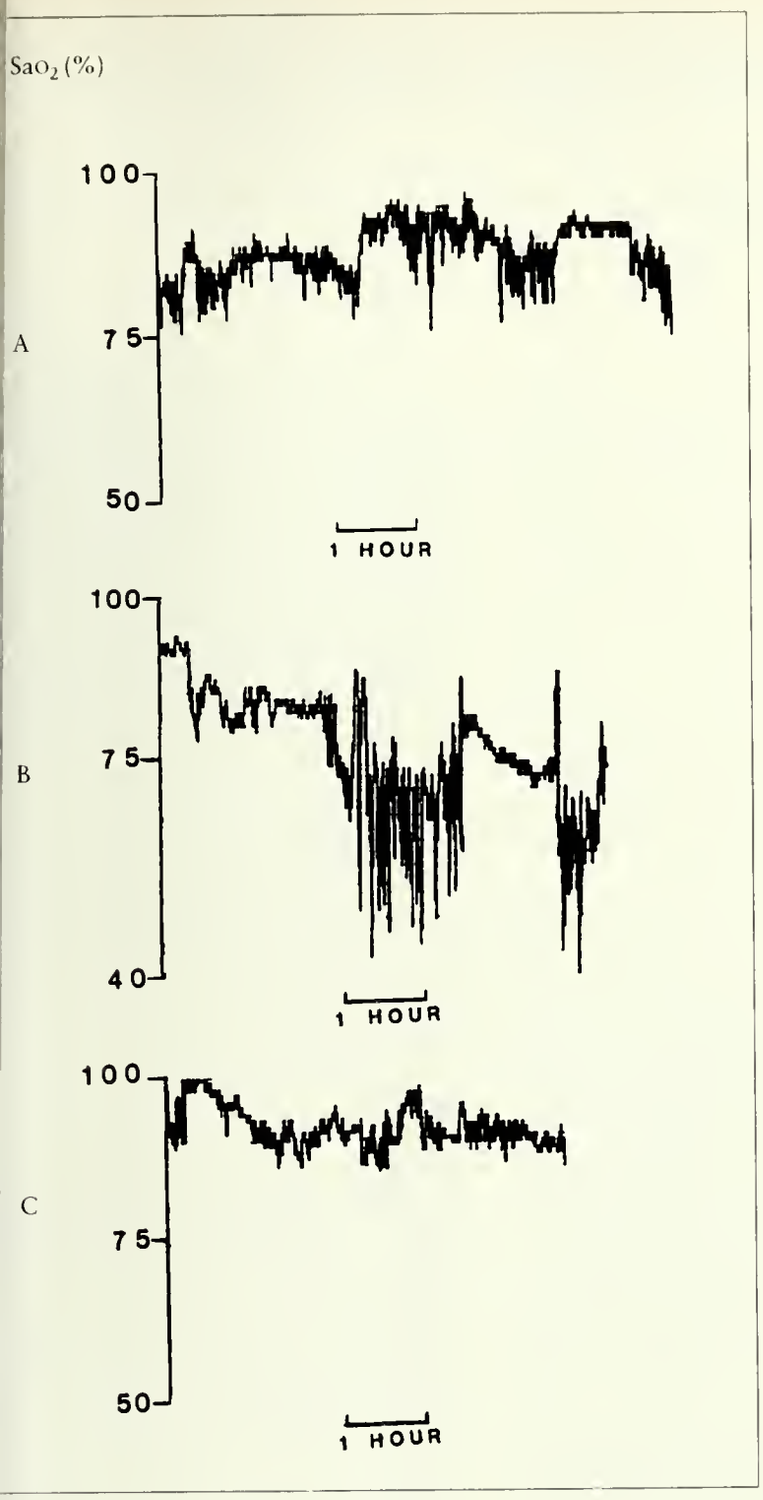

Fig 2. All-night recording of arterial oxyhemoglobin saturation (SaO_2). A, the control night; B, the night patient received supplemental oxygen; and C, the night nasal ventilation with PEEP was used.

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Effect of a field-based campaign against tobacco use for children in grades six through eight

STUART J. YOFFE, MD
HOMER TOLSON, PHD

An aggressive community-supported campaign against tobacco use was practiced for 3 years in Brenham, Tex, during the school years from 1987 through 1989. Physicians, role models, peers, and individuals with tobacco-related illnesses presented data to sixth, seventh, and eighth graders in the test program each year. Compared with students in two nonprogram adjacent school districts, the students in the test program seemed to decrease their desire to use tobacco in any form (smoking or chewing). A model prevention program has been developed that can be put into place in other rural or urban communities.

FIRST IN 1964 AND LATER in 1979, the US Surgeon General stated that smoking and tobacco usage in general constitute the number one health hazard in this country. We would be underestimating the annual mortality associated with tobacco usage if we accepted the often quoted figure of 350,000 deaths per year. The well-established association between smoking and hypertension, atherosclerosis, stroke, and cardiac disease tends to make an absolute rate of tobacco-related deaths difficult to calculate. To be complete with the estimation, we would have to include the large numbers of individuals with carcinoma of the lung, oral cancer, laryngeal cancer, esophageal cancer, bladder cancer, and cancer of the pancreas. Furthermore, even these totals do not consider the 60,000 estimated yearly deaths from chronic obstructive airway disease, a pathological category long known to be caused principally by cigarette smoking (1,2). In 1986, the US Department of Health and Human Resources published *The Health Consequences of Involuntary Smoking* (3). This publication clearly documents a relationship that is already well established with health-care providers — that involuntar smoking is a cause of disease, inclu ing lung cancer, in healthy nonsmok ers. Even the economics of smokin seems inescapable. Oster, Coldet and Kelly (4) estimated that a 35- t 39-year-old man who smokes tw packs of cigarettes a day generate expenses of more than $61,000 i lost productivity and increased medi cal care during his lifetime. All thes data lead to the inescapable conclu sion that the physicians and school of this nation must assist in any wa possible the development of pro grams that stop children from smok ing or using tobacco in any form And we must do it now!

METHODS

Procedures

No formal statistical hypotheses wer stated in that it was not administra tively possible to match the subject from pretesting to posttesting. Thus we felt that the assumptions neede for parametric analysis of the dat were not present in this study.

Program

In the mixed, urban-rural communi ty setting comprised of Washingto

Table 1. Structure of sessions presented to students.

Participant	Topic	Objective
Session 1		
Physician 1 (general surgeon)	Lung cancer	Educational
Physician 2 (internist)	Emphysema	Educational
Physician 3 (ENT)	Oral/laryngeal cancer	Educational
Individual with cancer	"Having cancer"	Emotional
Session 2		
Physician 4 (internist)	Heart disease & smoking	Educational
Physician 5 (pediatrician)	Passive smoking	Educational
Physician 6 (obstetrician)	Smoking & pregnancy	Educational
Ex-professional athlete	"Life's choices"	Role model
Male high school football star	"You don't have to smoke"	Peer model
Female high school honor student	"You don't have to smoke"	Peer model

Dr Yoffe, pediatrician and allergist, Brenham Independence Allergy Clinic, Route 2, Box 633, Brenham, TX 77833. Dr Tolson, professor, Texas A&M University, Department of Health and Physical Education, College Station, Tex. Send reprint requests to Dr Yoffe.

g 1. Smoking/dipping questionnaire, 1988.

rcle the name of your school: Brenham Bellville Navasota

rcle the grade you are in at present: 6th 7th 8th

ease read carefully before starting project: This is an opinion questionnaire — not a test. There are no correct or incorrect answers! *Do not* sign ur name. Please answer all the questions as honestly as possible. Circle one and *only one* answer for each opinion. Thank you!

pinion	Absolutely Yes	Probably Yes	No Opinion	Probably No	Absolutely No
. Dipping/smoking is a clean habit	1	2	3	4	5
2. Smoking causes cancer of the lungs.	1	2	3	4	5
3. Smoking is associated with emphysema of the lungs.	1	2	3	4	5
4. Chewing/dipping causes cancer of the mouth, lips, and tongue.	1	2	3	4	5
5. Most smokers wish they had never started smoking.	1	2	3	4	5
6. People that smoke are cool and "in".	1	2	3	4	5
7. Athletes and stars get paid to advertise smoking and dipping.	1	2	3	4	5
8. That my parents smoke means I probably will.	1	2	3	4	5
9. Once started, smoking is a habit easily stopped.	1	2	3	4	5
0. Smoking/dipping is a healthy habit.	1	2	3	4	5
1. Smoking is beneficial for increasing athletic skills.	1	2	3	4	5
2. Smoking is associated with heart disease.	1	2	3	4	5
3. If pregnant, smoking will hurt my baby.	1	2	3	4	5
4. If my friends smoke, then at some time I will be asked to smoke.	1	2	3	4	5
5. Smoking makes a person's breath pleasing.	1	2	3	4	5
6. My friends who smoke will not like me if I don't smoke.	1	2	3	4	5
7. Smoking/dipping makes me look older.	1	2	3	4	5
8. I will smoke/dip in the future.	1	2	3	4	5
9. Smoking/dipping makes me feel more comfortable.	1	2	3	4	5
0. I smoke/dip now.	1	2	3	4	5

ounty, Tex (mainly Brenham, Tex), campaign with broad community upport against tobacco use was ini- ated in the school year beginning eptember 1987 and ending May 990. The 3-year program consisted f a series of 10- to 15-minute lec- ures incorporated into two 1-hour rograms presented at the start of ach school year. The sessions took lace in Brenham Middle School, vhich was attended by sixth, sev- nth, and eighth graders in the com- nunity. The sessions occurred dur- ng the school day. The participants, heir topics, and their objectives are hown in Table 1.

The lecture series was comple- nented by each student being given, ree of charge, a T-shirt with a logo ıgainst tobacco use. The shirts were aid for by contributions from local usinesses and professional people n the Washington County area. The outh were asked to wear the green- ınd-white (school colors) shirts as ften as they liked and to commit hemselves not to use tobacco in any orm during the school year. Further upport came during Christmas va- cation, when children wearing these shirts were admitted free to movie theaters and given half-priced bowl- ing and roller skating treats. Also, local restaurants offered free soft drinks to students who were wearing the shirts while they were patrons. Local newspaper and radio provided excellent and widespread coverage of the program.

Questionnaire

To evaluate the effectiveness of the "Make Washington County Tobacco Free" program, a 20-item survey (Fig 1) was administered in September of each year to the sixth, seventh, and eighth graders attending the Brenham Middle School (referred to as School 1) before the lectures were given and before the shirts were distributed.

Table 2. Selected demographic characteristics of the school districts.

Characteristics	School 1 (Brenham)	School 2 (Bellville)	School 3 (Navasota)
Population			
City	13,000	2,860	7,460
County	26,000	17,726	18,800
School district attendance	4,247	1,622	2,395
County unemployment rate (%)	4.3	7.8	4.3
Median household income ($)	13,370	16,404	9,288
Persons by race in county (%)			
Caucasians	76	88	63.9
Black	22	10	31
Hispanic	2	2	4.2
Size (sq mi)			
City	6.96	5.00	6.30
County	614.00	633.00	801.00

Table 3. Means of total scores for classifications of school, grade, and time.

School	Mean
Brenham	79.05
Bellville	78.50
Navasota	76.64

Grade	Mean
6th	77.83
7th	78.37
8th	78.42

Time	Mean
Fall '87	78.38
Spring '88	78.88
Fall '88	79.59
Spring '89	77.64
Fall '89	77.05
Spring '90	77.77

School and Grade

School	6th	7th	8th
Brenham	78.04	79.43	79.72
Bellville	79.48	78.48	77.34
Navasota	76.60	76.18	77.05

School and Time

Time	Brenham	Bellville	Navasota
Fall '87	79.89	78.94	76.41
Spring '88	80.88	77.33	78.62
Fall '88	80.62	77.33	78.42
Spring '89	78.44	78.18	76.15
Fall '89	77.05	78.62	76.45
Spring '90	78.41	79.52	75.93

Grade & Time

Time	6th	7th	8th
Fall '87	78.05	78.11	78.9
Spring '88	78.57	78.77	79.3
Fall '88	79.27	79.58	79.9
Spring '89	77.53	78.25	77.1
Fall '89	75.89	77.91	77.8
Spring '90	78.24	77.63	77.3

Time, School, and Grade

	Brenham			Bellville			Navasota		
Time	6th	7th	8th	6th	7th	8th	6th	7th	8th
Fall '87	78.68	78.31	82.01	80.52	80.27	76.34	76.05	76.43	76.7
Spring '88	79.68	80.42	82.64	78.18	78.10	75.33	77.38	75.76	77.0
Fall '88	79.76	81.01	81.03	78.53	77.41	79.41	78.93	77.91	78.3
Spring '89	78.65	79.54	76.85	77.76	78.93	78.91	76.02	75.79	76.5
Fall '89	74.22	78.67	78.62	80.73	77.23	75.54	76.57	74.92	76.9
Spring '90	78.93	78.56	77.65	80.76	78.90	77.48	75.36	75.79	76.7

3-Year Tracking of 6th Graders

	Fall '87	Spring '88	Fall '88	Spring '89	Fall '89	Spring '9
Brenham	78.68	79.68	81.00	79.54	78.62	77.65
Control	78.28	78.77	77.66	77.86	76.57	75.36

This type of administration follows the guidelines suggested by several authors (5,6). Data were collected again with the same survey in May, the last month of the school year. The sixth, seventh, and eighth graders in the two schools (referred to as Schools 2 and 3) located in the counties adjacent to Washington County were used as control groups. These counties have essentially the same demographic characteristics (Table 2) as does Washington County. The demographic data for Schools 1 and 3 were based on estimated 1988 data, while those for School 2 were based on 1987 data. Neither of the control school districts provided any additional information against tobacco use to its students other than routine material for health class. By using all the responses of the three school districts, we can be reasonably sure the test samples are representative of sixth-, seventh-, and eighth-grade children in this entire area. By comparing the control groups' responses before and after the school year, we can determine what the shift in attitude regarding tobacco usage might be in the absence of an aggressive program against tobacco use, such as the one used in Washington County. And finally, by comparing the end-of-the-year results in Washington County with those of the two adjacent counties, we can ascertain whether the program in our test sample was effective in reducing the desire to smoke or in preventing a shift to an attitude favoring tobacco use that is often seen in elementary children (7).

Instrument scoring

The students responded to the items of the survey by choosing the Lickert-type response values that repre sented their attitudes towards th material in each statement. The nu merical value 5 indicated a stron response against tobacco use, and score of 1 reflected a strong attitud in favor of tobacco use. Items 2, 3 4, 5, 7, 12, 13, and 14 were revers scored to maintain the relationshi of a high numerical value bein equated to a strong attitude agains tobacco use. Each student's respons es to the first 19 items were summa ed to obtain a total score. Therefor a response of 5 to each of the 1 items would result in a total score o 95 and would indicate a very stron attitude against tobacco use. Con versely, a response of 1 to each iter would result in a total score of 1 and would reflect a very strong att tude favoring the use of tobacco.

Responses to items 20 were use

ble 4. A comparison of survey scores of sixth graders in test (Brenham) vs control schools over years.

ite	Survey Score	Numerical Change	Change, %
enham (starting score 78.7):			
ring '88	79.7	+1.0	+1.27
ll '88	81.0	+1.3	+1.65
ring '89	79.5	+0.8	+1.02
ll '89	78.6	-0.1	-0.13
ring '90	77.6	-1.1	-1.40
ontrol (starting score 78.3):			
ring '88	77.8	-0.5	-0.64
ll '88	77.7	-0.6	-0.77
ring '89	76.9	-1.4	-1.79
ll '89	76.6	-1.7	-2.17
ring '90	75.4	-2.9	-3.70

or classification purposes. Students ho responded with a 1 to question) were classified as users. Those reonding with a 5 were classified as onusers. The classifications were used indicate the prevalence of tobacco sage in the three school districts.

tatistical analysis

he total score was assumed to repsent interval-scale data, so the prerogram and postprogram total cores from each administration ere first subjected to summation rocedures; indications of central endency, variability, and subject ount were obtained. Because it was ot administratively possible to atch the responses of the subjects rom preprogram to postprogram, o statistical tests for changes in entral tendency were conducted vithin programs. Between-program eans and percent change over time ere used to judge the effect of the rogram against tobacco use.

ESULTS

he means obtained for all the data lerived from the study of these chilren are shown in Table 3. Several bservations are readily apparent rom these data. When the results of he children in our test group of Brenham Middle School who were ixth graders when the study was nitiated and who were presented he program three times are compared with the control sixth graders who were likewise followed for 3 consecutive years, we observe the ollowing (Fig 2):

Observation 1

From the first three surveys presented to the sixth graders in the control and test groups covering a full year (Fall 1987 to Fall 1988), the Brenham Middle School students demonstrated a rise in survey score from 78.7 to 81.0, while the control students showed a decline from 78.3 to 77.7. The higher the score on the survey, the more knowledge about tobacco is demonstrated and the more the attitude is against using tobacco.

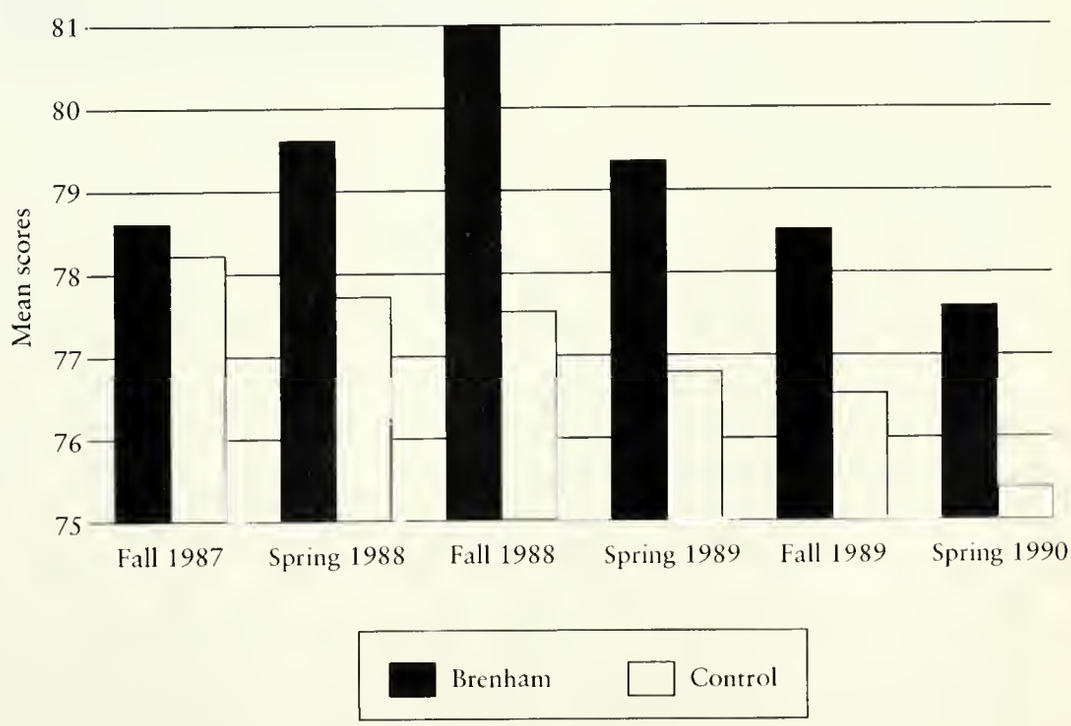
Observation 2

Starting with the initial survey results, we found that the scores of sixth graders in the test group declined less than did the scores of sixth graders in the control group during the entire 3-year test period (Table 4). Brenham sixth graders declined from 78.7 to 77.6; the control group declined from 78.3 to 75.4. That translates into a respective decline of 1.40% compared to 3.70% for the 3-year period. Thus, even though the scores of our test group of sixth graders declined gradually in the positive responsiveness to the antismoking campaign as they moved yearly through the middle school, they did so at a less rapid pace than did the students in the control group.

DISCUSSION

While findings of initial differences and the inability to look at changes within each school or possible interactions between schools, grade, and time are less than desirable from a

Fig 2. Chronological comparison of antismoking attitudes between sixth graders in Brenham vs control schools, Fall 1987 to Spring 1990.



design point of view, the results of the study shed important light on the effect of a campaign against tobacco use when we consider the overall shifts that occurred in these study groups. This is why more definitive conclusions of our statistical evaluations were not made. The most important shift was mentioned in observations 1 and 2. This trend is substantiated (2,3) in that as children at these grade levels progress through the school year, they become more and more protobacco oriented as a result of peer pressure, more exposure to tobacco, and other factors. We believe the campaign against tobacco use conducted in School 1 accounts for a slower trend toward tobacco use in that school in contrast to the faster trend in tobacco use in the control schools.

CONCLUSION

Considering the entire collection of data and the limitations of this study, we concluded that the results obtained support the stated observations. While these initial results are promising, we intend to follow this group of sixth graders throughout high school over the next 4 years to fully evaluate the effectiveness of the "Make Washington County Tobacco Free" campaign.

Further, arrangements have been made to implement this program in a school system in such a way that the assumptions needed for a more rigorous statistical analysis can be undertaken. This proposed endeavor will be completed during the 1991-through-1992 school year.

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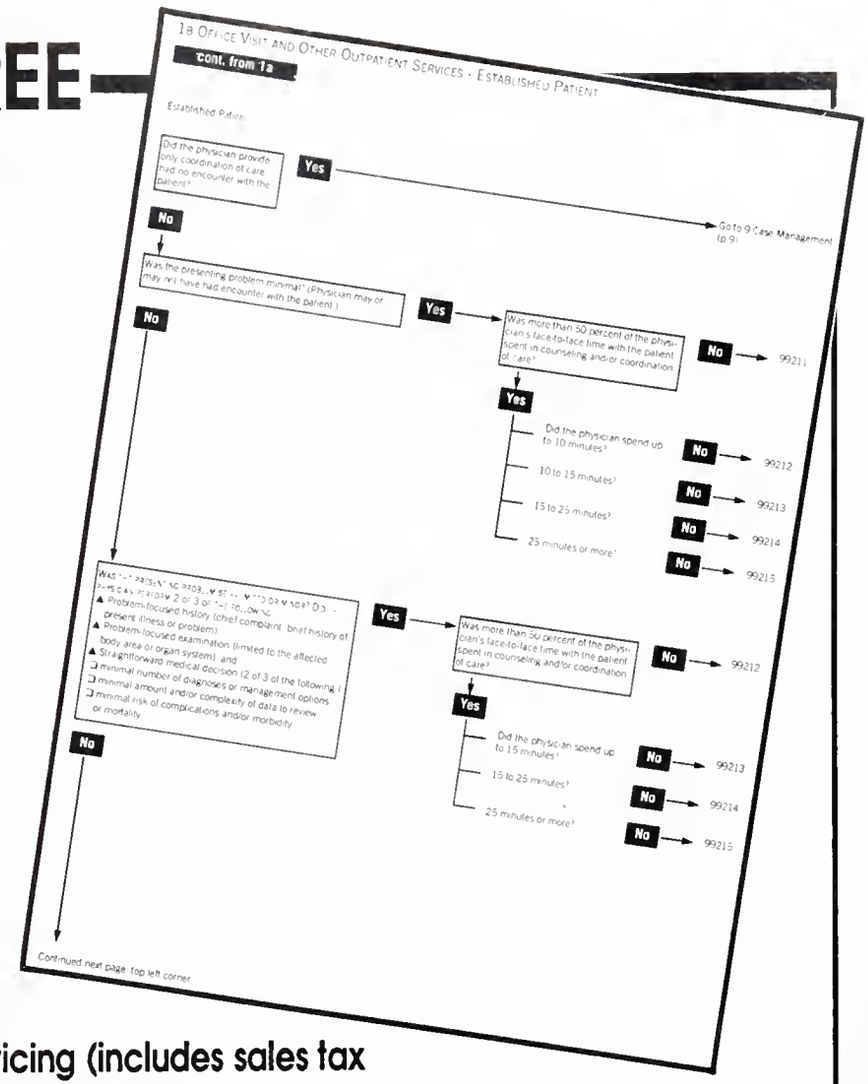

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Corpus Christi — Three physician group looking for BC/BE pediatrician to fill spot vacated by doctor who relocated out of state. Very busy, lucrative practice and still growing. Call or send CV to Len Leshin, MD, 3435 S. Alameda, Corpus Christi, TX 78411. 512 855-6257.

Dallas — A Pediatric Gastroenterologist is needed to establish practice in north Dallas. Excellent support from other pediatric sub-specialties. Send you CV to: Gordon Crawford, Manager, Professional Relations, Dept. II-2P, PO Box 1438, Louisville, KY 40201-1438. Or call 800-626-1590.

Pediatrics — Community 75 miles southwest of Houston recruiting to sponsor fourth pediatrician in town. Competitive income guarantee and relocation package, shared coverage. Stable economy, casual lifestyle. For details contact Practice Dynamics, 11222 Richmond, 125, Houston, TX 77082; 800 933-0911 or 713 531-0911.

continued on p 92

Some Gre
From Physicia

More doctors are turning to Physician Resource Network to satisfy their personal and profession needs. We offer the most comprehensive services available to assist you in the Texas market. To ensure this, an "opportunity profile" is provided for consideration prior to an interview being scheduled. And of course, there is never a fee to a physician seeking a practice opportunity.

ANESTHESIOLOGY

FORT WORTH
Anesthesiologists needed to join group practice serving 429-bed teaching hospital experiencing 5,000+ cases per year. Full range of anesthesia required (excluding hearts); supervise CRNAs. This position offers attractive life style with limited call. Contact: Barry Strittmatter.

NORTH CENTRAL TEXAS
Regional medical center in community of approximately 24,000 (serving referral area of 195,000) seeks anesthesiologist to perform full range of anesthesia services, including hearts. Shared call, modern facilities. Area renown for recreational opportunities. Competitive income guarantee to qualified physician. Good location; accessible to D/FW Metroplex. Contact: Vicki Truitt.

CARDIOLOGY

NORTHEAST TEXAS
Cardiology group seeks BE/BC invasive cardiologist for associate practice in NE Texas community. Referral area of 200,000. Modern medical facilities in town with more than 100 physicians. Progressive, family-oriented community with strong diversified economy, excellent schools. Many social and recreational opportunities. Generous compensation and benefits to high caliber physician.
Contact: Barry Strittmatter.

DIAGNOSTIC RADIOLOGY

PANHANDLE
Excellent private practice opportunity for BC/BE radiologist desirous of living in a community with good quality of life; great place to rear children. New hospital with modern equipment, including CT. Well trained supportive medical community. Generous incentive package to qualified candidate.
Contact: Jim Truitt.

FAMILY PRACTICE

FORT WORTH
Correctional health services opportunity available in Tarrant County. Orchestrate and supervise activities of professional health care team. Regular hours, limited call; good income and benefits.
Contact: Vicki Truitt.

CENTRAL TEXAS
A young, well-established family practice group and well-equipped, financially sound JCAHO accredited hospital are looking for two BC FPs to handle increasing patient volume. Located in Central Texas, eight miles from a major lake and 18-hole golf course/country club, this opportunity offers an outstanding life style to the physician who wishes to practice a full range of family medicine. Competitive incentive package available to qualified physician.
Contact: Barry Strittmatter.

FORT WORTH
Single specialty group and solo practice options available for board certified family practitioner with well-established Metroplex hospital. Competitive incentive package will be offered to qualified candidates. Contact: Barry Strittmatter.

HIGH PLAINS
Young well-trained BC FP seeks compatible FP associate for rapidly expanding family practice; includes OB. Community of 5,000 with service area of approximately 15,000. Excellent quality of life; good schools. Abundant outdoor recreational opportunities available, including nearby lake. City of 200,000 within 45 minutes. Generous financial package will be offered to qualified candidates.
Contact: Jim Truitt.

GASTROENTEROLOGY

NORTHEAST TEXAS
Three busy gastroenterologists seek fourth associate for group practice in NE Texas. Shared call, comprehensive benefit package, early partnership. Modern office and hospitals. Attractive community with strong, diversified economy, excellent schools. Many social and recreational opportunities.
Contact: Vicki Truitt.

INTERNAL MEDICINE

PANHANDLE
Excellent private practice opportunity for B physician in community of 8,000 (service ar 20,000). New hospital with state of the art diag equipment. Well-trained medical staff support this effort. Many outdoor recreational opportu available. Good school system. Excellent qua life. Generous incentive package.
Contact: Jim Truitt.

NORTHEAST TEXAS
Two internists seek third associate for busy pr in NE Texas community of 27,000 (referral ar 200,000+). Progressive, family-oriented comm with strong, diversified economy. excellent sch Social and recreational opportunities abo Modern medical facilities. Shared call; attra incentive package. Contact: Jim Truitt.

AMARILLO
Busy BC IM seeks associate for rapidly gro practice. Fully equipped office facilities. 35 hospital offering competitive incentive pack Excellent schools and quality of life; four se climate. Ideal location for outdoor sports enthu Easy access to snow and water skiing, boa fishing, etc. Contact: Jim Truitt.

SOUTH TEXAS
Thirty minutes from Padre Island. IM gr specializing in critical care, seeks fourth comp associate. Great climate and lifestyle. Recrea opportunities abound. Excellent income pote Contact: Barry Strittmatter.

NEUROLOGY

NORTHEAST TEXAS
Regional medical center serving 200,000 s BE/BC neurologist for practice; fee for ser shared call. Modern medical facilities. 100+ do in town. Progressive, family-oriented community strong, diversified economy, excellent schools. social and recreational opportunities. Gene incentive package to qualified physician.
Contact: Barry Strittmatter.

The TEXAS Specialists, Working In Texas For Te

pportunities
esource Network

TETRICS/GYNECOLOGY

THEAST TEXAS
onal medical center serving 200,000 seeks C OB/Gyn for private practice (to share call with other OB/Gyns). Progressive, family-oriented nunity with strong, diversified economy, lent schools. Many social and recreational rtunities. Competitive incentive package to ied physician. Contact: Jim Truitt.

COLOGY

THEAST TEXAS
logy group seeks BE/BC medical oncologist for ciate practice in NE Texas community with al area of 200,000. Modern medical facilities in with more than 100 physicians. New cancer er under construction. Progressive, family-ted community with strong, diversified economy, llent schools. Many social and recreational rtunities. Generous compensation and benefits gh caliber physician. Contact: Jim Truitt.

T WORTH
time, medical oncology position at teaching ital in D/FW Metroplex. Opportunity to direct on; develop full time oncology teaching service; with house staff. Modern facilities; infusion lab. ular hours and limited call. Competitive income benefits. Contact: Vicki Truitt.

OLARYNGOLOGY

RTHEAST TEXAS
onal medical center serving 200,000+ seeks tional otolaryngologist for private practice ortunity. Share call with recently trained BC . Progressive, family oriented community with ng, diversified economy, excellent schools. y social and recreational opportunities. petitive incentive package to qualified physician. tact: Jim Truitt.

DIATRICS

RTHEAST TEXAS
amic group of American trained BC pediatricians fourth associate for group practice in attractive mmunity of 27,000 (referral area of 200,000). gressive, family-oriented community with strong, rsified economy, excellent schools. Social and eational opportunities abound. Modern hospital Level II nursery and designated pediatric care . Shared call; excellent income and benefits; y partnership. Contact: Vicki Truitt.

NORTH CENTRAL TEXAS
Recently trained, BC female pediatrician seeks compatible associate for private practice. Share call with three other pediatricians. Competitive income and benefits. Attractive area with easy access to Dallas. Contact: Vicki Truitt.

SURGERY

SOUTH TEXAS
Within one hour of San Antonio. South Texas community seeks general surgeon for service area of 200,000. Candidate should be willing to do some primary care, initially. Hunting, fishing (fresh and salt water) and other recreational activities abound. Forty-two bed hospital will offer generous incentive package to qualified candidate.
Contact: Barry Strittmatter.

NORTHEAST TEXAS
Regional medical center serving 200, 000+ seeks vascular surgeon for private practice opportunity of 27,000. Progressive, family-oriented community with strong, diversified economy, excellent schools. Many social and recreational opportunities. More than 100 doctors in town. Shared call; competitive incentive package to qualified physician.
Contact: Jim Truitt.

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ABILENE PEDIATRICIAN

A Pediatrician is needed to establish practice in a medical complex next to our 160-bed hospital in the high-growth section of Abilene. This is an opportunity to establish a thriving practice with an attractive support package from our hospital. For more information send your CV to: Gordon Crawford, Manager, Professional Relations Humana, Dept. II-2F, P.O. Box 1438, Louisville, KY 40201-1438. Or call TOLL-FREE (800) 626-1590.

Physiatrist

College Station, Texas — In August 1990 the community's first Physiatrist established practice here and he is already overwhelmed. Another Physiatrist is now needed to associate. Our hospital here established a Physical Medicine & Rehabilitation Institute, with water therapy, this summer. Send CV to: Gordon Crawford, Professional Relations, Humana Inc., Dept. II-2B, PO Box 1438, Louisville, KY 40201-1438, Or call Toll Free 1-800-626-1590.

Radiology

Radiology — Immediate opening for BE/BC Radiologist in Dallas area outpatient practice. All modalities, mostly neuro-radiology. Send CV to PHYMED Imaging, 9603 White Rock Trail #100, Dallas, TX 75238.

Expanding 15-Physician multi-specialty group has excellent opportunity for a radiologist in friendly West Texas community of 25,000. Adjacent to a 153-bed modern hospital. Excellent guaranteed salary with no first year expenses in addition to benefits. Moving allowance also available. Direct inquiries or send CV to Gail Knous, Malone & Hogan Clinic, 1501 W 11th Place, Big Spring, TX 79720, 915 267-6361.

Radiologist Houston — Group in Medical Center adding associate. Must have MRI experience. Salary plus full benefits leading to partnership. For details contact Practice Dynamics, 11222 Richmond, #125, Houston, TX 77082; 800-933-0911 or 713 531-0911.

Diagnostic Radiologist with CT, MR, Interventional, US, Nuclear Medicine skills to join group of 7 Board Certified Radiologists. Two hospitals, private offices, service to nearby communities. Centrally located to San Antonio, Austin, Houston, Corpus Christi. Good family environment. Contact James Neumann, M.D., Box 3610, Victoria, TX 77903 512 578-0317.

Radiologist — Part-time position, approximately 6 hours per weekday. No nights or calls on weekends. Send CV to: PPM, 1075 Kingwood Dr, Ste 204B, Kingwood, Texas 77339. 713 358-8113.

Rheumatology

Corpus Christi — There is now an opportunity to establish private practice in offices next to our 263-bed hospital here with immediate referrals from our Humana Health Care Plan. Competitive financial and marketing assistance will be offered. Send CV to: Gordon Crawford, Professional Relations, Humana Inc., Dept II-2R, PO Box 1438, Louisville, KY 4021-1438. Or call Toll Free 800 626-1590.

College Station — A Rheumatologist is needed in this university community where our hospital has established a Physical Medicine and Rehabilitation Institute which includes water therapy. The successful candidate will be welcomed by a newly-established Physiatrist and our Orthopedic Surgeons, as many patients our now referred out of the community. Excellent financial assistance. Send your CV to: Gordon Crawford, Professional Relations, Humana, Inc. PO Box 1438, Dept II-2Q, Louisville, KY 40201-1438. Or call Toll Free 800 626-1590.

Other Opportunities

Position Available — Seeking BC/BE Family Practice, General Internist, Endocrinologist, OB/GYN to join established multi-specialty clinic. Excellent benefits and guarantee. Send CV to Leroy W. Kitch, Administrator, Skinner Clinic, 124 Dallas St., San Antonio, TX 78205.

Correctional Healthcare

Full time primary care Physicians & Psychiatrists, statewide adult correctional facility locations, competitive salary/excellent benefits/Physician student repayment program. Inquirers: TDCJ, Box 99, Personnel Annex, Huntsville, TX 77342-0099 or contact Glynda Baker, 409 294-2755.

Northeast Texas — Two outpatient clinics. Forty hours per week. No call. No hospital practice. Affiliated with multi-hospital system in Tyler, Texas. Other opportunities in Tyler area for pediatrics and family practice requiring hospital practice. Call 903 569-6124. Resume: PO Box 908, Mineola, TX 75773.

Austin — IM and FP to join Health Department primar care group practice. Diverse patients. Mostly clini based. Little call. STD, prenatal, wellchild clinic opport nities. Hospital and resident teaching with affiliated res dency programs. Competitive salary, benefits. Dr. Hin ATCHD, 15 Waller St., Austin, 78702, 512 469-2001.

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or send CV: 11140 Westheimer
Suite 144
Houston, TX 77042

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Progressive primary care medial group seeking mature, e perienced general internist or family practitioner. Multipl opportunities available. Varied patient base including FFS WC, Medicare, HMO, PPO. Stable, cohesive group, salar guarantee with incentive production formula. All the adva tages of an exclusive primary care group practice in Sa Antonio, Texas. Reply with CV to: Trinity Medical Grou George M. Rapier, MD, 4751 Hamilton Wolfe-Ste 105, Sa Antonio, TX 78229 or call 512 690-8515 FAX: 699-6170.

The Avanti/University Medical Group of Texas

The University Medical Group of Texas is looking for BE/BC Family Practice, Pediatric and ER physicians for full & part-time positions in a clinical setting. Base salary starts at $130,000 & up plus perks. Also looking for BC/BE (ER or FP or IM) to work in ER settings at an hourly rate of $60 and up.

For more information, call Robert Wallen @ (800) 735-7171, (713) 639-7099 or on weekends (713) 480-6590.

Occupational & Environmental Health Administrator

$57,252 to $85,884

e San Antonio Metropolitan Health District is seeking appli- ıts for its vacant Occupational & Environmental Health Ad- ıistrator position. This is professional management level ırk responsible for all medical and administrative activities rformed in the Bureau of Occupational & Environmental alth. This individual is responsible for the direction and pervision of all Food Service, Environmental Health, Vector ntrol, Animal Control and Injury Prevention activities in the alth District. This position also oversees the City of San tonio Occupational Health Division responsible for all pre- ployment physicals and City employee wellness programs. e performance of clinical duties in the various Health District nical programs is also required.

is position is responsible for a Bureau with an annual budget over $4,300,000 and 140 individuals. The position reports rectly to the Director of Health and may be called upon to act Acting Health officer for the City and County during the sence of the Director.

plicants for this position must possess a current license to actice medicine in the State of Texas, have completed a one ar internship in an approved patient care program and have o years of experience in public health to include one year of anagement and supervisory experience. Applicants with st-graduate training in Public Health, Environmental Health d/or Occupational Health will be given preference. Strong ministrative and supervisory experience is desired.

is position is with the City of San Antonio and includes an tractive fringe benefit and leave package. Annual compensa- n is negotiable depending upon training and experience ithin the range indicated above.

terested applicants should submit a current resume or vitae ong with salary requirements to:

s. Blanca G. Lozano, Services Administrator
n Antonio Metropolitan Health District
2 West Commerce
n Antonio, Texas 78285

cellent Opportunity — for a General Physician II at an 84 d JCAHO accredited Hospital. Requirements include li- nsed to practice medicine in Texas by the State Board Medical Examiners, certified or eligible for certification an American Board Specialty(preferably internist/pul- onologist/family practice). Competitive salary, educa- nal opportunities, plus other excellent state benefits hich include vesting at 5 years. Call or write to: South xas Hospital, Attn: Dalia C. Tovar, PO Box 592, Harli- n, Texas 78551, 512 423-3420, EEO/AA.

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M and FP needed — Houston — Join 16 physician group ractice in southwest Houston. Salary plus bonus for vo years, then partnership. For details, contact Prac- ce Dynamics, 11222 Richmond, Suite 125, Houston, X 77082; 800 933-0911 or 713 531-0911.

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Quality Used Medical Equipment — 1986 Toshiba SSH-65A Color flow Ultrasound, 1985 CGR 500T Mammography, Olympus CF TYPW 10L OES series Colonoscope, Formalens Lens Casting System, GE 8800 CT Scanner w/ BIRP Upgrade, and much more. Call MedExchange @ 214 824-5040 or fax to 214 823-9428.

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Internist's office and practice (Jan 1 or sooner). Ideal location, across parking lot from N.E. Baptist Hospital. Please contact Lawrence S. Higgins at 512 656-0311.

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Cardiology

Mar 7–10, 1992
State of the Art Echocardiography. Tucson, Ariz. Contact American College of Cardiology, Extramural Programs, Dept 5080, Washington, DC 20061-5080 (1-800) 897-5400

Mar 16–19, 1992
Cardiovascular Conference. Lake Louise, Alberta, Canada. Contact American College of Cardiology, Extramural Programs, Dept 5080, Washington, DC 20061-5080 (1-800) 897-5400

General Medicine

Mar 7, 1992
Geriatrics for the Primary Care Physician. Dallas. Contact St Paul Medical Center, Office of CME, 5909 Harry Hines Blvd, Dallas, TX 75235 (214) 879-3789

Internal Medicine

Mar 27–28, 1992
Recent Advances in Clinical Cardiac Electrophysiology. Galveston. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Neuroscience

Mar 3–4, 1992
Symposium on Neuroscience. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Obstetrics and Gynecology

Mar 28, 1992
Current Clinical Practice in Ob-Gyn. Dallas. Contact St Paul Medical Center, Office of CME, 5909 Harry Hines Blvd, Dallas, TX 75235 (214) 879-3789

Ophthalmology

Mar 6–7, 1992
Ophthalmology Symposium. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Mar 12–13, 1992
Ophthalmology in Developing Countries. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm Ls-105, San Francisco, CA, 94143-0742 (415) 476-4251

Mar 13–15, 1992
Cullen Eye Course: Clinical Advances in Ophthalmology. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

Mar 28, 1992
Ophthalmology Update and Alumni Meeting. Galveston. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Orthopedic Surgery

Mar 11–15, 1992
Orthopaedic Pathology Workshop. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Mar 20–21, 1992
Advances in Orthopaedic Surgery. Dallas. Contact St Paul Medical Center, Office of CME, 5909 Harry Hines Blvd, Dallas, TX 75235 (214) 879-3789

Otolaryngology

Mar 6–8, 1992
Maxillofacial Trauma. Galveston. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Pediatrics

Mar 6, 1992
Pediatric Endocrinology Conference. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Mar 27, 1992
Neonatal Conference. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Physical Medicine and Rehabilitation

Mar 9–19, 1992
Review Course in PM&R. Houston. Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

Plastic Surgery

Mar 7–8, 1992
Rhinoplasty Symposium: An Anatomic Approach. Dallas. Contact The Univers of Texas Southwestern Medical Cent Office of CME, 5323 Harry Hines Bl Dallas, TX 75235 (214) 688-2166

Radiology

Mar 20–22, 1992
Imaging in the Health Sciences. Housto Contact The University of Texas M.D. A derson Cancer Center, Conference Servic Box 131, 1515 Holcombe Blvd, Housto TX 77030 (713) 792-2222

APRIL

Critical Care

Apr 22–26, 1992
Critical Care Update. Washington, D Contact Center for Bio-Medical Commu cation, 80 W Madison Ave, Dumont, N 07628 (201) 385-8080

Family Practice

Apr 29–May 3, 1992
Family Medicine Review. Austin. Conta Scott & White Memorial Hosp, Office CME, 2401 S 31st St, Temple, TX 765 (817) 774-4083

General Medicine

Apr 4, 1992
Diabetes and Thyroid Disease Updat Dallas. Contact St Paul Medical Cent Office of CME, 5909 Harry Hines Blv Dallas, TX 75235 (214) 879-3789

Apr 25, 1992
Teaching Day in Rheumatic Disease. Da las. Contact St Paul Medical Center, Offi of CME, 5909 Harry Hines Blvd, Dalla TX 75235 (214) 879-3789

Oncology

Apr 1–4, 1992
Patterns and Mechanisms of Failure Aft Cancer Treatment. Houston. Contact Th University of Texas M.D. Anderson Canc Center, Conference Services, Box 13 1515 Holcombe Blvd, Houston, TX 7703 (713) 792-2222

Pediatrics

Apr 22, 1992
Management of Common Infection

ıshington, DC. Contact The University Texas Southwestern Medical Center, fice of CME, 5323 Harry Hines Blvd, llas, TX 75235 (214) 688-2166

ɔr 23–25, 1992
diatric Infectious Diseases Seminar. ashington, DC. Contact The University Texas Southwestern Medical Center, fice of CME, 5323 Harry Hines Blvd, ıllas, TX 75235 (214) 688-2166

ɔr 24–25, 1992
diatric Postgraduate Symposium. Hous-n. Contact Baylor College of Medicine, ffice of CME, One Baylor Plaza, Hous-n, TX 77030 (713) 798-6020

sk Management

ɔr 26, 1992
sk Management in the Pediatric Office. ashington, DC. Contact The University Texas Southwestern Medical Center, ffice of CME, 5323 Harry Hines Blvd, allas, TX 75235 (214) 688-2166

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pr 30–May 2, 1992
urrent Topics in General Surgery. Dallas. ontact The University of Texas South-estern Medical Center, Office of CME, 323 Harry Hines Blvd, Dallas, TX 75235 14) 688-2166

MAY

eneral Medicine

lay 9, 1992
ardiac Arrhythmias. Dallas. Contact St aul Medical Center, Office of CME, 5909 larry Hines Blvd, Dallas, TX 75235 (214) 79-3789

lay 20–23, 1992
ontroversies in Women's Health Care. capulco, Mexico. Contact Scott & White lemorial Hosp, Office of CME, 2401 S 1st St, Temple, TX 76508 (817) 774-4083

amily Medicine

lay 18–22, 1992
eview Course in Family Medicine. Hous-ɔn. Contact Baylor College of Medicine,)ffice of CME, One Baylor Plaza, Hous-ɔn, TX 77030 (713) 798-6020

ɔphthalmology

Aay 16–17, 1992
Ophthalmic Practice Management Symposium. San Antonio. Contact Texas Ophthalmological Association, 401 W 15th St, Austin, TX 78701 (1-800) 880-1300 or (512) 370-1504

Pathology

May 14–16, 1992
Current Issues in Surgical Pathology. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

May 16, 1992
Fine Needle Aspiration Basic Tutorial. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm Ls-105, San Francisco, CA, 94143-0742 (415) 476-4251

May 21–22, 1992
Current Issues in Anatomic Pathology. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm Ls-105, San Francisco, CA, 94143-0742 (415) 476-4251

Pediatrics

May 14–16, 1992
Advances & Controversies in Clinical Pediatrics. San Francisco. Contact Extended Programs, Rm LS-105, University of California School of Medicine, San Francisco, CA (415) 476-4251

JUNE

Obstetrics and Gynecology

June 18–19, 1992
Diagnosis & Management of Lower Genital Tract Neoplasia. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Orthopedic Surgery

June 5–7, 1992
Orthopaedic Surgery Review. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Otolaryngology

June 11–13, 1992
Otolaryngology Update. Galveston. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Pediatrics

June 15–19, 1992
Acute Care Pediatrics Review & Update. Hilton Head, SC. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

June 18–20, 1992
Pediatric Review & Update. Galveston. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Calendar of Meetings

•Denotes Texas meeting

February

Feb 29, 1992, Austin
•Texas Medical Association Winter Leadership Conference
Contact Jon Hornaday, 401 W 15th St, Austin, TX 78701 (1-800) 880-1300 or (512) 370-1345

March

Mar 4–6, 1992, Houston
•Texas Association of Obstetricians & Gynecologists Annual Meeting
Contact Terrence Kuhlmann, MD, 1007 E 41st St, Austin, TX 78751 (512) 451-3131

April

Apr 2–4, 1992, San Antonio
•Texas Urological Society Annual Meeting
Contact TUS, 401 West 15th St, Austin, TX 78701 (1-800) 880-1300 or (512) 370-1526

Apr 2–5, 1992, Houston
•Texas Radiological Society Annual Meeting
Contact TRS, 401 West 15th St, Austin, TX 78701 (1-800) 880-1300 or (512) 370-1507

May

May 14–17, 1992, San Antonio
•Texas Medical Association Annual Session
Contact TMA, 401 W 15th St, Austin, TX 78701 (1-800) 880-1300 or (512) 370-1450

May 16–17, 1992, San Antonio
•Texas Society of Anesthesiologists Interim Meeting
Contact TSA, 401 W 15th St, Ste 990, Austin, TX 78701 (512) 370-1659

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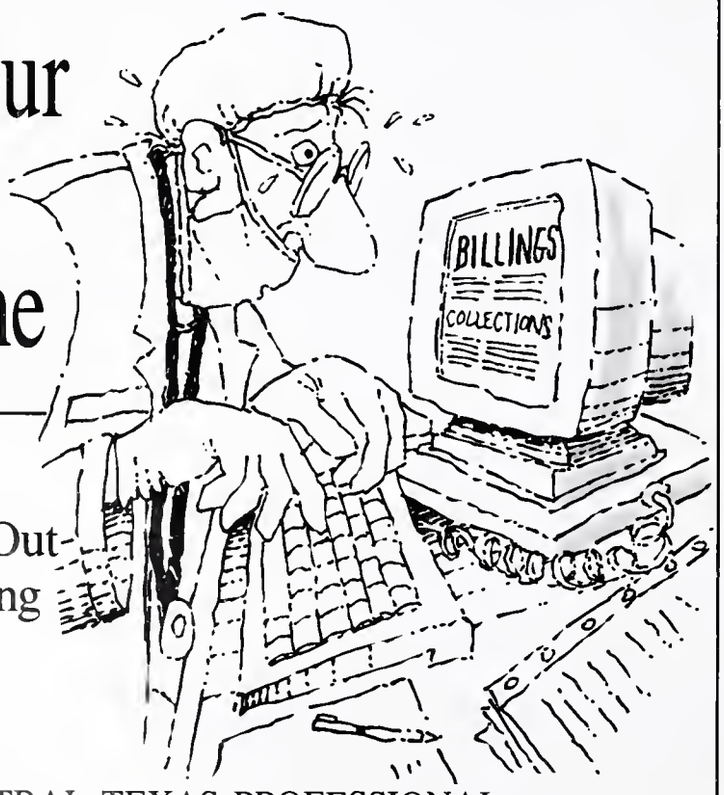

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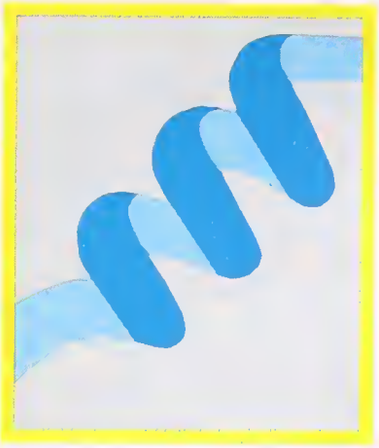

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Letters

Teen sex: just say no

When compared, two articles in the November 1991 issue of *Texas Medicine* show an odd attitude on the part of organized medicine and the Texas Medical Association.

The excellent article, "No ifs, ands, or butts — You *can* help patients quit," (pp 40–52) advocates the goal of helping people stop smoking because it is a health issue. In the section of the article called, "But what do I say?" physicians are advised to:

1. ask about smoking at every opportunity;
2. advise all smokers to stop;
3. assist the patient in stopping; and
4. arrange follow-up visits.

This advice about a health problem conflicts greatly with the suggestion given to physicians in an article about adolescent sexual activity ("Health risks of adolescent sexual activity are focus of TMA report," pp 60–61). The TMA Adolescent Health Task Force has produced a position paper for this health problem that reminds us that sexually transmitted diseases are dangerous.

Actually, if one understands this clearly, the problem of an adolescent having sex is certainly just as dangerous as the problem of adolescent smoking. Yet, we are advised by the Adolescent Task Force to provide "comprehensive health care for adolescents," and to "establish funding for STD and AIDS research, treatment, and support services for adolescents."

There is not one word about an approach similar to the one recommended about smoking. I find this odd. Sexual activity during the teenage years is especially dangerous. A study published in *Pediatrics* showed very clearly that good sex education is not changing the sexual activity of young people (1).

I strongly advocate that we stop compounding our error. It has been clearly shown that the soft way in which we have been approaching this problem of adolescent sexuality and STD is not working. I strongly urge the much more directive and much more successful approach that TMA is advocating for people who smoke. We need to:

1. ask adolescents about sexual activity at every opportunity;
2. advise them to stop having sex;
3. assist them in stopping sex; and
4. arrange follow-up visits until they get married to encourage them to reserve sex until marriage.

Studies show that when this approach is taken, kids *are* able to wait to have sex or even stop sex they may be engaging in, and they *do* hear what is being said.

Joe S. McIlhaney, Jr, MD
811 E 32nd St,
Austin, TX 78705.

References

1. Stout JW, Rivara FP. Schools and sex education: does it work? *Pediatrics.* 1989(83):375–379.

Physicians Benevolent Fund: please do your part

The article in *Texas Medicine* in December 1991 (pp 9–10) regarding the Physicians Benevolent Fund (PBF) was quite timely. PBF has served as a "safety net" for Texas physicians and their families at times of financial crisis since its establishment some 30 years ago.

Unfortunately this "safety net" is developing holes. With plummeting interest rates, stable donations, and an increasing number of applicants, the lines on the graph plotting contributions versus assistance have crossed, and there is a danger of depletion of the fund.

Awareness of the PBF and the good it does for our medical community and its families is the first step in building up the fund, thereby mending the holes in the "safety net."

PBF is a joint effort of the Texas Medical Association and the TMA Auxiliary. If one considers only the roughly 21,000 active members of the TMA, a $10 per capita per year donation would result in $210,000 per year for the fund. Additional contributions from the medical auxiliary could increase this figure significantly.

I hope each member of the TMA will become aware of the PBF and do his or her part to keep this fund available to Texas physicians and their families in times of financial crisis.

Mary Ann Mullican, MD
2518 Del Monte Dr,
Houston, TX 77019.

Firearms article raises questions

I read the article "Firearm-related mortality in Texas (1985–1990)" by Zane et al [*Texas Medicine*, November 1991, pp 63–65] with interest. I'm afraid that the article raises more questions than it answers, and the overall tone of the article points an inappropriately accusatory finger at the firearm. The real source of the prob-

lem is not the firearm, but us.

One of the two most common causes of firearm-associated death was suicide. What proportion of all Texas suicide is committed with firearms? Will removing firearms from the initial reach of those committed to end their lives really change the eventual outcome? Articles that attempt to link risk of suicide to availability of firearms are flawed, yet widely published and quoted (1). Wouldn't we be better served by increasing public education about depressive disorders and suicide, or increasing funding to outpatient mental health screening, prevention, and treatment?

How large is the population of Texans committing suicide with firearms compared to those Texans committing suicide by tobacco use, unsafe vehicle practices, or chronic dietary indiscretion? Wouldn't emphasizing prevention and screening efforts in this larger, more ably influenced population be more cost-effective?

Homicide was named as the other firearm "culprit." Murder with edged and blunt weapons in my area of Texas is increasing at a more rapid rate than that of firearm homicide. Should we look to control these weapons as well? There is not a realistic way of limiting access of felons to firearms. Even if there were, would it truly reduce homicide rates? Experience in New Jersey, California, and Massachusetts, where handgun ownership has been legislatively limited, suggests that this is not the case. In fact, murder rates have increased in some of these areas.

How many homicides are related to drug abuse? Shouldn't we really be taking steps to curb this societal ill? How many homicides are related to gang or family violence? Wouldn't the preventive dollar be better spent on social services in these areas instead of drafting and enforcing firearm restrictions? Shouldn't we really try to halt these social problems by building a stronger America through improving social services for the needy, crime education and prevention, and reducing joblessness and homelessness?

Don't we really desire *crime* control? Is gun control really going to achieve crime control? Shouldn't we really be emphasizing tougher judges, longer sentences, less cluttered courts, no parole for repeat or violent offenders, and expanding prison systems until such time that social change reduces crime?

Shouldn't we really expand violence prevention programs in the school, the home, and the community? Time and time again in medicine and sociology we see the superior efficacy of screening and prevention over that of treatment . . . why are we not building on this knowledge referent to societal violence? Why are we "treating the symptom" rather than the cause? Why are we blinded to the true issues rather than the sensationalism of gun control?

Who will defend us when a felon enters our home and threatens our families' lives? Clearly, at currently funded levels, law enforcement agencies cannot. Contention that this type of crime will decrease with gun control is completely unfounded. In fact, I contend that this type of violence will increase when the citizenry is disarmed and criminals no longer fear threats to their own well-being when engaged in criminal activity.

No substantive proof exists that reducing the availability of firearms reduces violent death. Although the authors' article was of interest, their credibility was lost when they went beyond reporting the facts and statistics and quoted the recommendations of the National Committee for Injury Prevention and Control referent to limiting legitimate firearm availability and use.

Your readership would appreciate a more thoughtful review of firearm-associated articles before they are published.

Mark G. Doherty, MD
2926 Beluche Dr,
Galveston, TX 77551.

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IN RESPONSE

DR DOHERTY HIGHLIGHTS many important and complex issues in his review of our article. His solutions to the variety of societal and psychological factors underlying the serious firearm-related mortality problem are interesting but yet complex.

Our vital statistics review was intended to characterize the distribution of firearm-related deaths and to demonstrate this cause of death as an important public health issue in Texas. In 1990, firearms surpassed motor vehicles as the leading cause of injury death in the state.

As Dr Doherty suggests, there has been only a modicum of research into the role of firearm availability on injury death rates. Recently, important work conducted by University of Maryland researchers demonstrated the beneficial effect of restrictive licensure of handguns on homicide and suicide deaths in the

District of Columbia (1). We agree that more work is needed to understand the multitude of complex issues surrounding this problem.

The etiology of firearm mortality is clearly multifactorial. One of the major circumstances of firearm-related deaths is suicide. The most common method of suicide in Texas is the firearm; nearly three quarters (74%) of all suicides in the state in 1990 were accomplished with a gun, according to the Bureau of Vital Statistics, Texas Department of Health (TDH). The literature suggests that the availability of firearms in the home may increase the risk of suicide among adolescents (2). An important question that warrants further research is: If firearms are not available to individuals with suicidal intentions, how many attempts might be channeled to less lethal methods (3)?

More than two thirds (68%) of homicides in Texas in 1990 involved guns (TDH Bureau of Vital Statistics). The data clearly demonstrated the existence of populations at increased risk of being murdered with a gun. These groups might be targeted for violence prevention and intervention efforts. Interestingly, murders do not appear to be random acts committed by strangers. For those murders for which offender-victim relationships are known, more than three quarters (78%) of the murder victims in Texas during 1990 knew their assailant(s) (4).

Accidents are a third circumstance of firearm-related deaths. More than 150 children in Texas have been unintentionally killed by guns since 1985 (TDH Bureau of Vital Statistics). A 1991 federal report from the Program Evaluation and Methodology Division of the US General Accounting Office indicated that nearly one of every three (31%) deaths from accidental firearm discharges in the country could be prevented by incorporating two safety devices on the gun: a child-proof safety device that automatically engages and a device that indicates whether or not a gun is loaded.

Physicians should encourage parents with children to practice firearm safety in the home by following the suggestions of the American Academy of Pediatrics: never keep a loaded gun in the house; keep guns and ammunition locked in separate places; always treat a gun as if it were loaded and ready to fire; never allow children access to guns; and ensure that these precautions have been carried out wherever children might visit (5).

The tragedy of these statistics lies in the fact that most, if not all, of these deaths are preventable. As we learn more about the epidemiology of firearm-related deaths, a better understanding of prevention strategies will follow. From that scientific basis, decision-makers can design and implement effective policies that would reduce the tragic impact of firearm-related mortality.

David F. Zane, MS
Mary Jo Preece
Erik K. Svenkerud, MD, MPH
Patti J. Patterson, MD, MPH
Injury Control Program,
Epidemiology Division,
Texas Department of Health,
1100 W 49th St,
Austin, TX 78756.

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2. Brent DA, Perper JA, Allman CJ, Moritz GM, Wartella ME, Zelenak JP. The presence and accessibility of firearms in the homes of adolescent suicides — a case-control study. *JAMA.* 1991;266: 2989–2995.
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4. *Crime in Texas.* Austin, Tex: Uniform Crime Reporting/Crime Records Division, Texas Department of Public Safety; 1990.
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Upfront

Indo-American physicians adopt "A Legacy of Caring" with vigor

IN A STRIKING SHOW OF commitment and caring, a group of physicians from India who have made Texas home have contributed almost one quarter of the total funds raised to date by A Legacy of Caring, the campaign to create a permanent endowment in the Texas Medical Association Education and Research Foundation.

At the end of January, more than $950,000 had been donated by members of the Texas Indo-American Physicians Society (TIPS). The total raised from physicians statewide by A Legacy of Caring stood at $3,944,995.

According to Ashok M. Balsaver, MD, a pathologist in Houston and president of TIPS, Indian physicians see the campaign as an opportunity to demonstrate both their concern for the health of Texans and their solidarity with TMA.

"A Legacy of Caring is a good way for the physicians of Texas to do something for the people of Texas and, as physicians of Texas, we wanted to take part in it," said Dr Balsaver.

Nick N. Shroff, MD, a urologist in Midland and former president of TIPS, echoed the sentiment.

"Texas has been good to us, and we felt that it would be appropriate to pitch in and help," he said.

The endowment fund will support public health and medical information and education programs that have the highest opportunity for improving the health of Texans.

It's worth noting that the idea of participating in the campaign came originally not from TMA, but from Indian physicians directly. Dr Shroff and Nalin H. Tolia, MD, an ophthalmologist in Odessa, saw the campaign as a way for Indian physicians to participate with other Texas physicians in a "good cause." The project has since been formally adopted by TIPS.

A worthy goal

TIPS' goal is to raise $2 million from its members. The emphasis has been on gifts of charitable life insurance, which offer an affordable way to be generous and have proven a popular way for Texas physicians to make significant and lasting gifts.

According to Dr Shroff, the goal was chosen because it was TMA's initial goal for the whole campaign.

"When we heard that the initial target was $2 million, we thought that probably we could get the $2 million through TIPS alone," said Dr Shroff.

Given that the Indian physicians began their appeal for support to the campaign just last fall, they have made great progress, say TMA campaign officials.

Thanks from TMA to the Indian physicians has been expressed by Max C. Butler, MD, Houston, former TMA president and state campaign chairman.

"TMA-ERF applauds the collective effort of TIPS and is proud to recognize its major contribution to the campaign," said Dr Butler. "TIPS members will be recognized as pacesetters in the establishment of A Legacy of Caring endowment."

An organization to distinguish *and* unite

More than 1,000 Indian physicians practice in Texas, and they represent a significant percentage of the approximately 6,000 foreign medical graduates in the state.

TIPS was formed in 1985 by Indian physicians in Houston, Dallas, and northwest Texas, who were later joined by their San Antonio counterparts. Today, the organization has more than 380 dues-paying members in four chapters.

It serves cultural, social, and professional functions for its members, as well as recognizing the distinctiveness of Indian physicians. However, its members stress their desire to be "part of the whole."

"We want to be part of everything else," said Dr Balsaver. "We don't want to be seen as something separate. That's not the intent of our organization. We want to work within TMA."

A Legacy of Caring

If you can help

Both Drs Balsaver and Shroff were eager to encourage all physicians — not just those from India — to support the campaign.

"Physicians have been more fortunate than some of the other people in the state of Texas, and we feel that since we are doing well, it would be nice to reciprocate in some way, to help some of the less fortunate people," said Dr Shroff.

Dr Balsaver agreed: "I'd like to send a message not just to the Indian physicians but to all physicians in Texas to take part in A Legacy of Caring."

Campaign officials emphasize that donors who pledge $5,000 or more to A Legacy of Caring campaign by April 1, 1992, will receive special recognition as "founders" of

the endowment fund. Physicians affiliated with TIPS who contribute $50,000 or more may have their names listed under TIPS' name on the donor wall in the new TMA building in Austin.

Texas physicians who give at one of four levels will receive recognition by having their names displayed prominently on the donor wall: Benefactor, $50,000 or more; Patron, $20,000 to $49,999; Honor Roll, $5,000 to $19,999; and Friend, $1,000 to $4,999.

For further information about supporting A Legacy of Caring, contact the TMA Resource Development Department, 401 W 15th St, Austin, TX 78701, phone (800) 880-1300 or (512) 370-1370.

TMA widens border health conference impact

TRANSFORMING THE enthusiasm at TMA's Third Annual Border Health Conference, held last October, into tangible improvements in the dire health conditions along Texas' border with Mexico requires much sustained effort. Two communication projects demonstrate TMA's commitment to "spreading the word" about border health needs.

TMA produced and distributed a video news release (VNR) — only the second TMA has ever produced — at the conference, which was distributed to statewide media via satellite. The VNR drew attention to the spread of border health conditions and TMA's efforts to establish a US-Mexico Environmental and Health Commission.

Also distributed statewide was the speech by TMA president Sam A. Nixon, MD, Houston, at the border health conference. Nearly 3,000 copies of Dr Nixon's speech were mailed to statewide media, the Texas Legislature, chambers of commerce, select business organizations and associations, hospitals, county medical societies, and specialty societies.

Annual Session luncheon celebrates New World

MEDICAL MEETINGS DON'T usually include anniversary celebrations, but Texas Medical Association's Annual Session, May 14–17, 1992, in San Antonio, will celebrate not only its 125th annual session, but also the 500th anniversary of the New World.

One of the features at the annual membership luncheon, Saturday, May 16, will be "Finding America," a multimedia presentation about the discovery and development of the North American continent. Nine projectors and triple screens are used to interpret the meaning and impact of this milestone being commemorated worldwide this year.

Photographed in 31 states and several foreign countries by Nolan Moore, executive director of Printing Industries Association of Texas, the show has been a crowd pleaser since its premiere last year.

Also scheduled during the luncheon, which runs from 12:15 to 2:15 pm, is the installation of William G. Gamel, MD, Austin, as the 127th president of the Texas Medical Association. Dr Gamel succeeds Sam A. Nixon, MD, Houston.

The luncheon program also includes presentation of the Anson Jones awards to Texas news media. Each year, TMA chooses members of the Texas media to recognize for excellence in communicating health information to the public.

The luncheon will be held in the North Banquet Hall of the San Antonio Convention Center. An order form for tickets ($25 per person) is in the Advance Program, mailed to all TMA members last month, or on page 60 of the February issue of *Texas Medicine*. Tickets also will be available during Annual Session.

For further information about the programming planned at Annual Session, see the article on p 28 of this issue of *Texas Medicine* or contact the TMA department of annual session and meeting management, 401 W 15th St, Austin, TX 78701, (800) 370-1300 or (512) 370-1450/1451.

Clarification

A sentence in "High-Dose thrombolytic therapy and angioplasty for thrombosis in a subacute femoropopliteal bypass graft," by John A. Dieck, MD, and Jaime Benrey, MD, published in the November 1991 issue of *Texas Medicine*, pp 80–82, needs clarification. The sentence, as published on p 80, read: "When admitted to our institution, the patient was given minoxidil, atenolol, hydrochlorothiazide, and enalapril." In order to make it clear that the patient was already receiving those drugs when hospitalized, the sentence should have read: "Prior to admission to our institution, the patient's drug therapy had consisted of minoxidil, atenolol, hydrochlorothiazide, and enalapril, which were continued."

TMA Auxiliary forges a new alliance

my Wilson
xecutive Director, Texas Medical Associa-on Auxiliary

Originally, it was all style and no substance.

Prior to 1918, the doctors' pouses who accompanied their hus-ands to TMA's annual conventions vere cherished for their social skills. These "Visiting Ladies" served as ıostesses for their husbands and or-ganized other wives for luncheons, eas, and tours. And that was it.

By 1918, women were beginning o take on causes, expanding their sphere into the public realm. Doc-ors' spouses, while never militant, were influenced by women's need to serve humanity through meaningful accomplishments outside the home. Logically, they chose to align them-selves with the medical profession "to extend the aims of the medical profession, through the wives of the doctors, to the various women's or-ganizations which look to advance in health and education . . ."

The Woman's Auxiliary to the Texas Medical Association, organized by 300 women in May 1918 in San Antonio, worked to support the war effort and to educate the public on various health issues. They paralleled TMA's organizational structure and began growing by leaps and bounds, going on to organize the AMA Auxil-iary 4 years later. State after state fol-lowed suit, and a network of partners to medicine emerged to supplement the work of organized medicine all over the country.

By 1977, the percentage of wom-en physicians was increasing dra-matically, and the auxiliary ac-knowledged this by changing its name to the Texas Medical Associa-tion Auxiliary and beginning the evolution to "non gender-specific" programming, meeting times and volunteer opportunities for men, and a concerted effort to attract more men to the fold.

Times are still a'changing. More and more women are re-turning to school, begin-ning their own profes-sions and businesses, and young women are hard-pressed to find time for social clubs, coffees, and midday luncheon-fashion show events. And men, an even larger percentage of the auxiliary's potential membership, are still not joining in significant numbers. The 90s are here; the 21st Century is around the corner. How should we meet these challenges?

TEXAS MEDICAL ASSOCIATION ALLIANCE

Physician Spouses Joining To Care

Proposed logo, name, and slogan.

The TMA Auxiliary has decided that it's time for another evolutionary leap. An ad hoc committee on image development has theorized that an organization with a higher profile, known for its activism, effectiveness, and strength, willing to change with the times, will find mem-bership marketing a bit easier in to-day's stressful, busy atmosphere. Therefore, following a series of meet-ings and related actions spanning al-most a year, they have engaged the Austin firm of M.H. Keller and Asso-ciates to conduct scientific research and unbiased surveys and develop a marketing plan to assure the organiza-tion's viability in years to come.

The research phase, consisting of focus groups in diverse areas of the state, and a randomly-selected 500-person telephone survey, was com-pleted and reported to the commit-tee by Thanksgiving last year. The most significant findings are:

- The word "auxiliary" is per-ceived as denoting: secondary in importance, composed exclusive-ly of women; old fashioned; eli-tist; people who don't work.
- Most auxiliary mem-bers joined to meet new people with simi-lar interests; they stayed to contribute to their communities and are discouraged when they feel the organiza-tion fails to respond to important community needs or pursues a purely social direction.
- All felt programming should be substantive and of interest to men and women, young and old.
- High marks for impor-tance were given to is-sues relating to chil-dren, such as chemical dependency, AIDS education, and parenting; help for the elderly also had high priority.
- Virtually all asked for their mail to be addressed using their own first names.
- Most felt the auxiliary needs a new direction, common goals, expand-ed service projects.
- Reaction to the word "alliance" produced comments such as: equal cooperation, collaboration, part-ner, teamwork, and goal-oriented.

With the survey stage behind them, auxiliary leaders will move forward to implement the recommendations re-sulting from this study. Texas auxil-iary delegates have a rare opportunity

at their May convention to strengthen and shape the organization that works to support the goals of organized medicine. Among the proposals being considered are:

1. a new logo that will visually link the organization to Texas Medical Association;
2. a name change to Texas Medical Association Alliance; and
3. a slogan, or tag line, to further define the organization and its role in the structure: Physician Spouses Joining to Care.

The implementation phase will include training in membership marketing, offered to county auxiliary leaders, to communicate the organization's new image, unified purpose, goals, accomplishments, and partnership with the Texas Medical Association. Further, an information plan will be developed to give the organization an identifiable image in the eyes of the public, the media, the legislature, prospective members, and physicians.

The style of the "Visiting Ladies" is still there. The substance added by the auxiliary made it an invaluable partner to the medical association. The recognition that times, people, and attitudes change can add new dimension and a wealth of new talent to the emerging organization of "physician spouses joining to care." ★

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
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3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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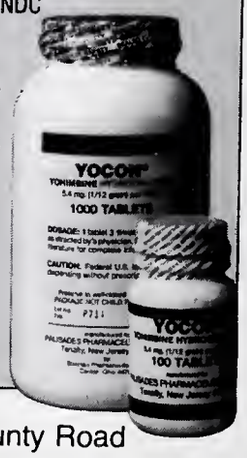

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1. How do you deal with the pathology report in your chart which is unknown to you?
   What issues are raised by this situation?

2. What is the internist's responsibility in this case, if any?

3. The pathologist's?

4. Considering the patient is elderly and probably incurable at the time of the visit, what hidden factor may likely cause a suit to be filed in spite of questionable damages?

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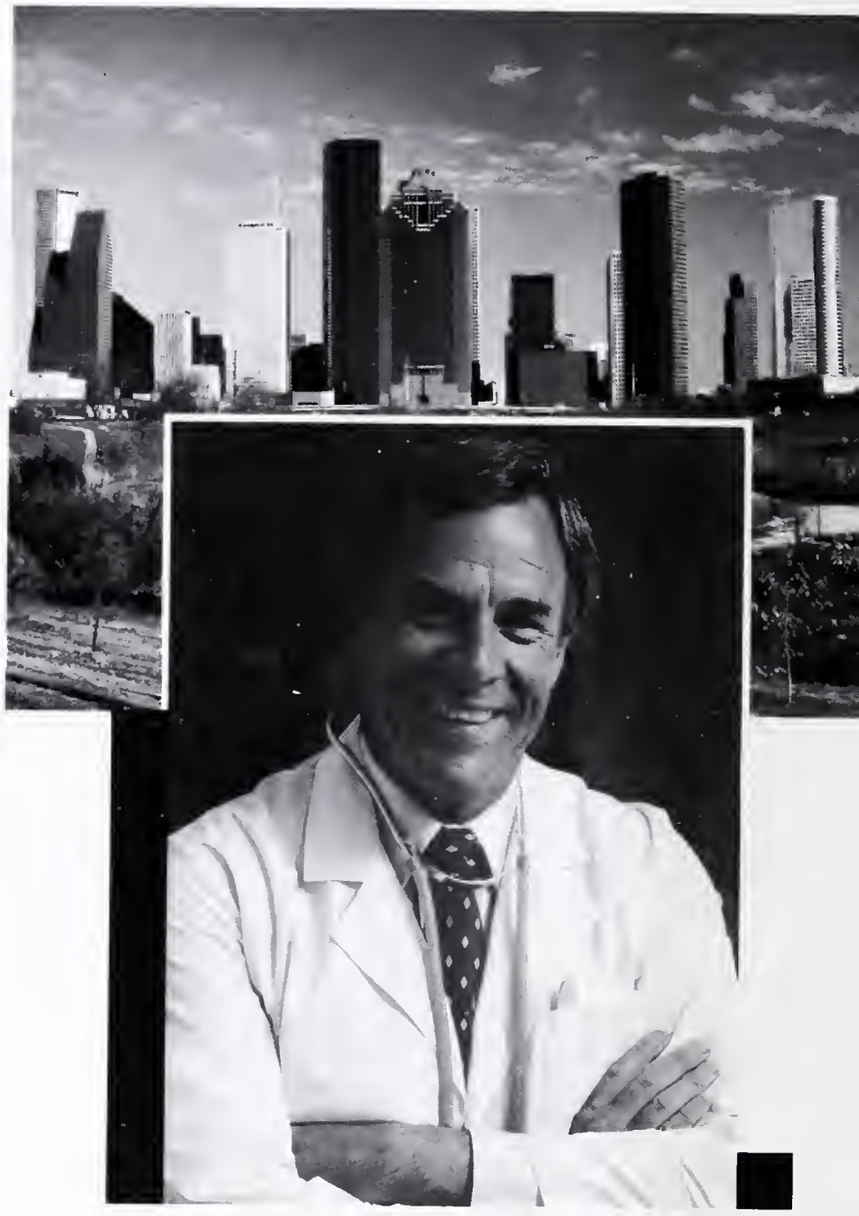

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People

NEWSMAKERS

James Burkeholder, MD, a Lubbock pediatrician, was presented the Award of Hippocrates by the Lubbock-Crosby-Garza County Medical Society. This award recognizes Dr Burkeholder for his outstanding community service with the Easter Seals board, the Head Start program, and the mental health advisory board of the county medical society.

Drs Fernando F. Cabanillas, Waun Ki Hong, Marsha D. McNeese, and J. Taylor Wharton of M.D. Anderson Cancer Center in Houston will be included in a forthcoming book, *The Best Doctors in America*. The 3,840 physicians cited in this publication were selected by a nationwide poll of leading doctors in the United States.

The Dallas-Fort Worth Medical Foundation has awarded Physician of the Year to **H. Reg McDaniel, MD,** chief pathologist of the Dallas-Fort Worth Medical Center. Dr McDaniel's research contributions include the invention of acemannan, an immune modulator used in the treatment of AIDS, leukemia, and other autoimmune diseases.

TMA president and family physician **Sam A. Nixon, MD,** received the AMA Education and Research Foundation Award in Health Education for his efforts in developing a health education curriculum for Houston area school children. He also directed the production of a paperback book about AIDS. Two million copies of *AIDS: A Guide for Survival* have been distributed by the Harris County Medical Society.

Sam A. Nixon, MD

Courtney M. Townsend, Jr, MD, director of the Surgical Research Center at The University of Texas Medical Branch at Galveston has been elected 1992 president-elect of the American Pancreatic Association.

Dallas psychiatrist **Agnes V. Whitley, MD,** received the Professional of the Year Award for 1991 from the Alliance for the Mentally Ill/Dallas.

Robert L. Wick Jr, MD, an Arlington general preventive medicine practitioner, has been decorated by the surgeon general with the US Army's Distinguished Service Medal, which is the highest award given in peacetime. Dr Wick also was given the Meritorious Service Medal for his service during Desert Shield/Desert Storm.

Please let *Texas Medicine* know about your honors and achievements.

Criteria for inclusion in the Newsmakers section are: TMA member; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, Texas Medicine, *401 W 15th St, Austin, TX 78701.*

OBITUARIES

Willard Earl Adams, MD, 58; Garland; Tulane University School of Medicine, 1959; died December 14, 1991.

Joseph Berry Cobb, MD, 66; Dallas; The University of Texas Southwestern Medical School, 1947; died December 17, 1991.

Pierre Gerard Craig Sr, MD, 60; Dallas; University of Haiti Medical School, 1957; died December 28, 1991.

Gilbert H. Fletcher, MD, 80; Houston; University of Brussels Medical School, 1941; died January 11, 1992.

Everett C. Fox, MD, 89; Dallas; Baylor College of Medicine, 1928; died December 22, 1991.

Gordon M. Gafford, MD, 71; Mineral Wells; The University of Texas Southwestern Medical School, 1956; died December 12, 1991.

Malcolm Cress Maley, MD, 71; Texarkana; The University of Texas Southwestern Medical School, 1945; reported deceased.

John Raymond McCarville, MD, 69; El Paso; University of Colorado Medical Center, 1949; died November 11, 1991.

William F. Powell, MD, 69; Gainesville; The University of Texas Southwestern Medical School, 1945; died January 1, 1992.

Edgar C. White, MD, 79; Nacogdoches; University of Louisville School of Medicine, 1937; died December 22, 1991.

Legislative Affairs

Senator wants psychiatric hospital legislation debated in special session

THE CHAIRMAN OF A SPECIAL Senate subcommittee investigating complaints against private psychiatric hospitals has asked Gov Ann Richards to include the issue in any special legislative session called this year.

However, a Texas Supreme Court ruling on public school finance handed down January 30 appeared to forestall the need for any immediate special sessions.

State Sen Mike Moncrief (D-Fort Worth) asked Governor Richards to let lawmakers debate the psychiatric hospital issue if she called them into session to write a new public education finance plan.

Senator Moncrief's subcommittee has been investigating complaints against private psychiatric hospitals, including inappropriate admissions practices and overbilling.

The January 30 Supreme Court decision, as most Capitol observers expected, declared the state's school funding system unconstitutional. The court, however, gave lawmakers until June 1993 to devise a new plan. That means the issue can be addressed in the next regular session, which convenes next January.

Lawmakers had not expected the court to allow the public schools to operate under the current law that long. In fact, it was felt the timing of the decision at the end of January simply was to allow school districts to collect most of their tax revenues for the current year, then force lawmakers to have a new finance system in place for next year.

While unlikely, Governor Richards still could call a special session on school finance or another issue. If that happens, legislation on psychiatric hospitals probably would be filed almost immediately.

Senator Chris Harris, an Arlington Republican who sits on Senator Moncrief's subcommittee, filed a package of bills during the recent special session on redistricting. Senator Harris' legislative aide Connie Johnson said those bills, along with others, definitely would be filed again.

Senator Harris' bills would:

- give any agency that licenses, certifies, permits, registers, or recognizes health-care professionals the authority to discipline those professionals for offering, paying, or accepting fees for referring a patient to a particular mental hospital or facility;
- limit the number of claims a mental hospital or facility can make under the Crime Victims Compensation Act;
- require that a physician on staff of a mental hospital or facility, rather than the facility administrator, admit a minor patient; and that a physician determine whether voluntary inpatient services are necessary;
- reduce from 96 to 24 hours the time within which a patient who files a written request for release must be discharged, but also require hospitals to keep the patient the full 24 hours;
- require that a patient or patient's legal guardian be provided a list of medications prescribed to the patient while in the hospital;
- require that a patient's confidential records be made available upon request by the patient; and
- transfer to a Department of Protective and Regulating Services the authority to enforce operating and licensure laws concerning private mental hospitals, chemical dependency treatment facilities, and hospitals that permit the use of narcotics in drug treatment programs.

Staff members in the TMA division of public affairs have analyzed Senator Harris' legislation, but the Council on Legislation has taken no position on the bills.

Leslie Lemon, staff director for the Senate Health and Human Services Committee, said the Moncrief subcommittee also is in the process of drafting legislation in case a special session occurs. Ms Lemon said the committee's package may include areas not addressed in the Harris bills.

That panel's proposals likely will address admissions procedures for voluntary patients, civil penalties against psychiatric facilities, and clarification of statutes on illegal remuneration for patient referrals.

"Some of the payment for referral scenarios we've heard did not involve a health-care provider and that's what the bill presently addresses," she said. "It doesn't address a probation officer or a school counselor or an attorney or anyone else."

Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs section of* Texas Medicine.

All articles in Texas Medicine *that mention Texas Medical Association's stance on state legislation are defined as "legislative advertising," according to Tex Govt Code Ann §305.027. That law requires disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in* Texas Medicine*: Robert G. Mickey, Executive Vice President, TMA, 401 W 15th St, Austin, TX 78701.*

Party primaries to proceed March 10

Despite uncertainty created by court challenges to legislative redistricting plans, the Democratic and Republican primaries apparently will be held as scheduled March 10. Texas Medical Association Political Action Committee chairman Richard Stoebner, MD, of San Angelo, urges all Texas Medical Association, TEXPAC, and TMA Auxiliary members to vote and to get involved in important political campaigns in their areas.

"Widespread grass roots involvement in the political process is essential if we are to be successful in getting our viewpoint across to our elected officials," Dr Stoebner said.

Among important races in which TEXPAC has made endorsements are three seats on the Texas Supreme Court. In Place 1, TEXPAC has endorsed Dallas appellate judge Craig Enoch over Charles Ben Howell in the Republican primary. TEXPAC has endorsed incumbents Eugene Cook, Republican, in Place 2 and Jack Hightower, Democrat, in Place 3.

"The fair and impartial balance of the court restored by our election victories in 1988 and upheld in 1990 is once again at stake in 1992," Dr Stoebner said. "This year's races will be no less critical and, in due course, will affect any meaningful tort reform."

Contributions to Texas Medical Association PAC (TEXPAC), Texas Medical Association PAC-Statewide (TEXPAC-Statewide), and American Medical Association PAC (AMPAC) are not deductible as charitable contributions for federal income tax purposes.

Voluntary political contributions to TEXPAC are shared with AMPAC. Contributions are not limited to the suggested amount. Neither TMA or AMA will favor or disadvantage anyone based on the amounts or failure to make contributions. Contributions to TEXPAC and AMPAC are subject to Federal Election Commission regulations. Federal election law prohibits TMA from soliciting donations from persons who are not in its solicitable class (eg, TMA members and their families). All donations received from persons who are not in TMA's solicitable class will be returned.

TMA Auxiliary member Susie Tonymon of Fort Worth has been awarded the 2nd Annual June Bratcher Award for Political Action. The award is presented annually by the Board of Directors of the Texas Medical Association Political Action Committee to a physician spouse who has become significantly involved in a federal or state level political campaign. It is named for Mrs Everett Bratcher, a longtime member of the TEXPAC board. Mrs Tonyman received the award at the Auxiliary meeting at the Fall Leadership Conference last September.

Health task force begins work

The Governor's Health Policy Task Force has launched an ambitious schedule of public hearings and work sessions designed to produce by August 31 preliminary recommendations for solving access to care problems in Texas.

Following public hearings in Austin on January 30 and 31, the task force organized itself into four subcommittees that will examine essential health services, cost issues, payment mechanisms, and health-care delivery systems. The subcommittees are scheduled to meet twice each month. As many as 11 additional public hearings across the state also are planned.

The task force has set August 31 as the target date for completing its preliminary report. It plans to solicit comments on the report during September and October and issue its final recommendations November 1.

The panel was created by Gov Ann Richards to study access to care problems and make recommendations to the 73rd Texas Legislature in 1993. It includes 14 public members appointed by Governor Richards, six state senators appointed by Lt Gov Bob Bullock, and six state representatives appointed by House Speaker Gib Lewis.

During the January 30–31 hearings, former TMA President Jim Bob Brame, MD, of Eldorado, participated in a panel discussion with hospital representatives, nurses, and other providers. Dr Brame told the task force that Texas' access to care problems are being aggravated by a growing population, our lengthy border with Mexico, lack of health-care providers and services in many rural areas, a high teen pregnancy rate, failure to provide basic childhood immunizations, and a "patchwork" health-care delivery system for our poor.

Dr Brame outlined the five-point plan for solving access to care problems recommended in 1991 by the TMA Ad Hoc Committee on Financing and Availability of Health Insurance. He also said physicians are "ready and willing to contribute" to creating a system to increase accessibility to health care. ★

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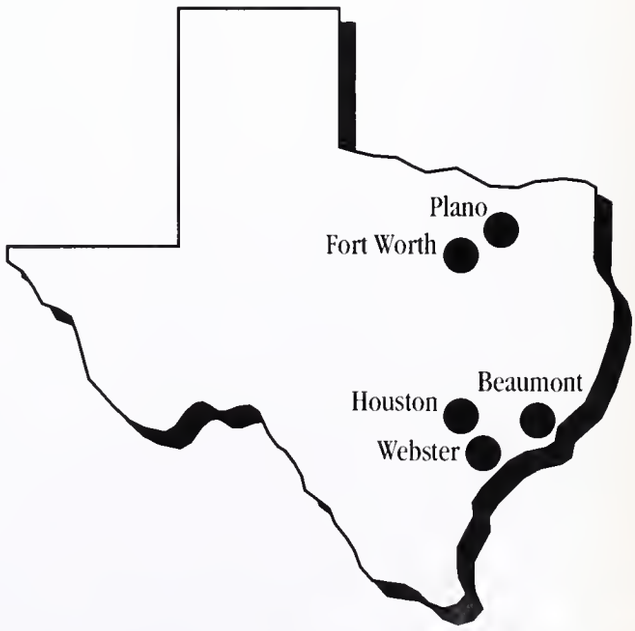

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Science and Education

Tumor registries: a weapon in fight against cancer

PHYSICIANS HAVE A HOST of weapons at their disposal in the battle against cancer: powerful drugs, new surgical techniques, diagnostic tools such as MRI and CT scans, and a multimillion-dollar army of research scientists exploring every facet of the disease.

But another tool often remains in the background of the fight against cancer: statistics. Cancer registries and tumor registries that track the deadly disease might not be as thrilling as the latest high-tech research breakthroughs, but physicians and public health officials say keeping track of the disease is the best way to measure medicine's progress in fighting it.

Texas has both a statewide cancer registry, operated by the Texas Department of Health (TDH), and about 50 individual tumor registries.

While state health officials recently noted a major milestone in the statewide cancer registry — a 90% compliance rate by hospitals in reporting — Texas is behind the rest of the country in the formation of hospital-based or regional tumor registries, which track statistics on a smaller scale and allow a comprehensive evaluation of the disease in a localized area.

The statewide cancer registry at TDH has made great strides in the past 2 years, according to Linda Lloyd, PhD, director of the program.

"The first time we really started keeping track of how we were doing was April 1990, when statewide, the level of reporting was 24%," she said. "So this is the first time in the state that we are over 90%. In December 1991, we stood at 93%."

Dr Lloyd attributes the turnaround in reporting to an acknowledgment on the part of hospitals, physicians, and other health-care professionals of the importance of having information from a registry to assist in planning and evaluating intervention.

"We have to know what's happening before we know what to do about it," she said.

Dr Lloyd said TDH has also tried to make reporting easier for physicians and hospitals by reducing the amount of data that must be collected, installing a toll-free number for calling in reports, and using electronic reporting capabilities.

"About 50% of our data is reported electronically," she said. "Tied in with that is the Texas Cancer Council and the Texas Hospital Association, which both promoted electronic reporting in the development of cancer registries."

> "WE HAVE TO KNOW WHAT'S HAPPENING BEFORE WE KNOW WHAT TO DO ABOUT IT."

TDH provides training to hospital staff members, mostly medical records technicians, who are assigned to report data to the cancer registry.

With the statewide registry enjoying a record level of participation, public health officials and many physicians feel that now is the time to increase the number of tumor registries in Texas.

According to TDH records, there are currently 51 tumor registries in the state. A tumor registry is set up in an individual hospital or among several hospitals in a city or region to collect and analyze cancer data, audit and review the quality of care given cancer patients, and serve as a sponsoring organization for conferences and symposia.

Robert F. Peterson, MD, a pathologist at Scott and White Clinic in Temple who has been involved with the clinic's tumor registry for more than 25 years, said a registry is an important part of a hospital cancer program, adding that the data generated by a registry can be useful to both individual patients and for hospitals.

"We keep a yearly record of our return visits, and during the year 1990, 4,922 of the 10,095 alive patients being followed for malignancy made at least one return visit to the clinic. About 50% of all patients with malignancy made at least one return visit to the clinic," he said. "I think that not only does the patient benefit by being reminded to come in regularly for follow-up care, but the hospital and clinics also benefit."

Dr Peterson said the American College of Surgeons (ACoS) is the primary organization that accredits tumor registries and maintains the standards for hospital cancer programs under which they must operate.

"The ACoS has a booklet that spells out the steps needed to set up a hospital cancer program," he said. "We have seen many benefits from this program, not the least of which is an improvement in patient care over the years."

One example of how a registry is able to use its data is the A.B. Gold-

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

Information for this column comes from a variety of sources, including academic institutions, state and federal agencies, and private institutions. To submit items of interest, write Texas Medicine, *Science and Education Editor, 401 W 15th St, Austin, TX 78701.*

Diabetes researchers produce artificial beta cells

The University of Texas Southwestern Medical Center at Dallas — Diabetes researchers here report that they have taken the first steps toward creation of a genetically engineered "artificial beta cell," which would be a major step in treating insulin-dependent diabetes mellitus (IDDM). The researchers, who published their findings in the January 15 *Proceedings of the National Academy of Sciences*, say the future development of an artificial beta cell could offer a potential alternative to human islet-cell transplantation. Engineered cells were created by adding a piece of DNA to cells derived from the pituitary gland, conferring the function of insulin release in response to changes in the external concentration of glucose. IDDM is expected to affect more than 1 million Americans by the year 2000.

More potent heart drug undergoing research

The University of Texas Medical School at Houston — A drug that shows promise in treating heart attacks is undergoing a randomized study in 20 centers across the United States, including the UT Medical School at Houston. Richard W. Smalling, MD, PhD, associate professor of internal medicine and codirector of the division of cardiology at UT, and Joseph Loscalzo, MD, PhD, of Harvard University, are directing the study in the United States. The drug, rPA, has been shown to open arteries in half the time of TPA, or Activase, a medication used for the past 6 years to treat acute myocardial infarction. The drug rPA stays in the body longer than TPA, researchers said.

New Century Campaign tops $150 million in donations

Baylor College of Medicine — The New Century Campaign, a fund to create research programs and recruit faculty at Baylor College of Medicine, has reached the $150 million milestone, according to school officials. The campaign reached the $100 million mark last year. Since that time, some $50 million in pledges from corporations, foundations, organizations, and individuals including Baylor alumni, have placed the campaign only $25 million shy of its $175 million goal. "Something that was once only a dream is now concrete in the form of new laboratories, funding earmarked for new buildings, and other endeavors," said Daniel C. Arnold, Baylor trustee and chairman of the campaign. The campaign will fund research in heart disease, aging, genetic medicine, analysis of the eye, and training of ophthalmic surgeons, according to Baylor officials.

DNA's use in courtroom cross-examined in study

The University of Texas Health Science Center at Houston — A technique using DNA typing that provides a way to identify violent criminals has been defended as an "invaluable weapon against crime" by Ranjit Chakraborty, PhD, a professor of genetics at UTHSC. Dr Chakraborty coauthored a rebuttal in the journal *Science* to a recent article that claims the use of DNA typing in courtroom evidence is premature, that genetic blueprints may vary among subcultures. Scientists performing DNA typing analyze small amounts of blood, hair, skin, or semen. If the cells in these match the cells of a suspect, evidence is strong that the suspect committed the crime. Dr Chakraborty's rebuttal argues that since the odds of two people having the same DNA profile are 1 in 10 billion to 1 in 100 billion, it is highly unlikely that any 2 of the 6 billion people in the world would match.

ston Regional Tumor Registry in Amarillo, founded in 1963 by the Potter-Randall County Medical Society. The registry, which currently serves seven hospitals in the Texas Panhandle, developed statistics in 1981 to justify the need for construction of the Harrington Cancer Center in Amarillo, according to an article in *Panhandle Health* magazine.

State public health officials and the Texas Cancer Council say more local and regional registries are needed throughout the state.

Emily Untermeyer, executive director of the Texas Cancer Council, said one main objective of the Texas Cancer Plan is to increase the number of hospitals with ACoS-approved community cancer care programs.

"Our plan talks about the steps that public, private, and volunteer sectors need to take to bring about these facilities," she said. "They need technical assistance to help them gain ACoS approvals. They need to encourage teaching hospitals to qualify, to increase the skills of tumor registrars, and develop cancer committees and more. It's a very high priority for us."

She added that hospitals must make a financial commitment to operate a registry, even in these tight financial times.

"In the economic struggles that hospitals face, when they go looking for things to cut, things like moving towards ACoS accreditation (for the registry) is one of the things they cut," she said, adding that the short-term savings is often less than the potential long-term benefit of a tumor registry.

The Texas Medical Association stands in strong support of both the statewide cancer registry and tumor registries in local hospitals. TMA endorses and encourages medical staffs

to support establishment of a cancer registry in the hospital to provide data needed for evaluation of cancer management and development of continuing education programs.

For information and guidelines on how to start a tumor registry, contact the Texas Cancer Council at (512) 463-3190. Also, the American College of Surgeons *Cancer Program Manual* is available through its Committee on Cancer at 55 E Erie St, Chicago, IL, 60611, or by calling (312) 664-4050.

"Super Saturday" program planned at Annual Session

AMONG THE MYRIAD programs and symposia offered at TMA's 125th Annual Session, to be held in San Antonio May 14–17, will be two special programs offered on May 16, also known as "Super Saturday."

Both general sessions will deal with critical issues facing physicians in the 1990s.

The morning session from 9 am until noon will focus on "The Public Image of the Physician." According to Dale Willimack, director of the TMA annual session and meeting management department, recent studies have shown that the public image of the physician is fading.

"At a time when modern technology enables the physician to do more for the patient, respect for the medical practitioner is declining," she said. "To change the public's perception, physicians need to heal their image."

A panel of experts will explore what the public thinks about physicians in general and ways in which their image could be improved. Patient-physician communications, media impact, physician and office staff attitude, time and money, and people skills will be discussed in a town hall format.

Panelists will include Edward E. Rosenbaum, MD, author of the book *A Taste of My Own Medicine*, the basis of the screenplay for the film *The Doctor*; Joseph W. Synan, leadership consultant; and Steve Booton, MD, who conducts numerous physician-patient communication workshops. The moderator will be Dennis Johnson, health reporter for WFAA-TV in Dallas.

The afternoon session, from 2:30 to 5 pm, will explore the brave new world of Medicare's physician payment system. The program is entitled "What's In, What's Out in Medicare: A Discussion With the Experts."

"What's out," said Mrs Willimack, "is the way physicians have been reimbursed by Medicare since 1967. What's in is the resource-based relative value scale payment system, which went into effect January 1 of this year."

The program will feature J. Michael Hudson, deputy administrator of the Health Care Financing Administration, who will give an overview of the new system. Also on the panel will be Harold Whittington, a medical practice consultant based in Dallas, who will discuss understanding and improving third party reimbursement. The moderator will be Angela Vierville of KSAT-TV in San Antonio.

There will also be some 225 CME credit hours of programming planned during the 4 days of the session. House of Delegates sessions, reference committees, scientific programs, and exhibits will be staged at the San Antonio Convention Center. Headquarters hotels for the sessions will be Marriott Riverwalk, the Marriott Rivercenter, the Hilton Palacio del Rio, and the Hyatt Regency. Several major social events are planned during the session.

There is no registration fee for TMA members. For more information, see the four-page Annual Session insert in the January and February issues of *Texas Medicine* or contact the TMA annual session department at (800) 880-1300 or (512) 370-1451.

TMA, others protest plan to eliminate student loan deferments

WHILE BECOMING A physician may be both personally and financially rewarding, the cost of obtaining a medical education often leaves graduates facing a crushing load of debt.

So it is with more than just casual interest that medical students, residents, and young physicians are watching two measures in Congress that could severely limit or eliminate the current system of deferments available on student loans.

Lawmakers are considering a reauthorization of the Higher Education Act. The bill numbers are HR 3553 in the House and S 1150 in the Senate. Under current provisions of the act, students may defer pay-

TMA LIBRARY SCHEDULES COMPUTER COURSES

OKAY, SO YOU'VE FIGURED OUT HOW your new computer can schedule patients, keep your billing up to date, and maybe you've even used it to laser-blast Zorok invaders from the Garaxian nebula.

But have you *really* explored the vast array of medical information available through your PC?

The TMA library is offering a series of classes to help physicians unlock the information-gathering and retrieval power of their machines.

"There is a huge amount of medical information, journal articles, and more available through on-line data bases and CD-ROM (compact disk-read only memory) that's there simply for the asking," said Miriam Blum, TMA online services librarian. "Through these classes, we can show a doctor how to get the most out of the money he or she has spent on a computer."

Category I CME credit is earned upon completion of each course.

Courses scheduled for 1992 are:

- **April 25 — The Basics of Searching MEDLINE.** A full-day course that introduces the basic MEDLINE search commands, teaches system vocabulary, and acquaints physicians with tools to give them access to the more than 6 million citations in the MEDLINE data base. (8 hours) $100 for members, $150 nonmembers, $10 students.
- **June 17 — CD-ROM Search Techniques.** A class designed to teach techniques for searching CD-ROM-based data bases such as SilverPlatter and others, which contain bibliographic citations from more than 3,000 medical journals. (3 hours) $50 members, $100 nonmembers, $10 students.
- **August 1 — Getting Organized: File Management for the Busy Physician.** A class to help physicians and their assistants organize reprint files. Basic file management skills, including indexing, will be explored, as well as a review of current file management software. (3 hours) $50 members, $100 nonmembers, $10 students.
- **November 7 — Grateful Med: Computer Access to Information.** A workshop to encourage health professionals to search the National Library of Medicine's computerized data bases, such as MEDLINE, using a menu-driven software package called Grateful Med. Individual instruction and hands-on training enable participants to immediately use their new skills. (4 hours) $50 members, $100 nonmembers, $10 students.

The above courses will all be taught at the TMA library at 401 W 15th St in Austin.

Class size is limited, but if demand is high enough, additional courses will be added. For more information or to register, contact Miriam Blum in the TMA library at (800)-880-1300 or (512) 370-1547.

ments of Title IV student loans for 2 years and obtain forbearance until the completion of training, after which they must repay their loans within 10 years. No interest accrues on the loan principal during a period of deferment; interest does accrue during a period of forbearance.

Changes proposed under the reauthorization bills would eliminate deferment for Title IV student loans with the exception of "in-school," "unemployment," and "economic hardship." The Senate version also limits the maximum forbearance to the first 3 years of residency training and restricts the availability of forbearance to those residents whose debt equals or exceeds 20% of their gross income.

Major W. Bradshaw, MD, associate dean for student affairs at Baylor College of Medicine in Houston, said such a change would not only hurt current medical students, but could contribute to the already dwindling number of medical school applications.

"This is going to further discourage people from pursuing a career in medicine," said Dr Bradshaw. "This will serve to decrease medicine as an attractive option for people who are considering where they are headed in their careers."

He added that the new regulations would tend to hurt those already having the most difficult time with getting a medical education.

"I think it's going to make it more difficult for us to attract minority applicants and people from underserved areas," he said. "The government says they want doctors to go back to small towns and inner cities, and then they discourage those very people from entering medicine with something like this. It really doesn't make a whole lot of sense."

Yvonne Russell, MD, PhD, assistant vice president for student affairs at The University of Texas Medical Branch at Galveston, said her school attempts to prepare its students for dealing with their obligations when they graduate.

"We do individual budgeting for each student. Our staff meet with individual students, look at their budgets, and tell them what they can afford to borrow in terms of what they ought to be able to live on," she said. "We also have discussions with each student on how they are going to pay it back and how that will affect their future life. Most of our students would strongly prefer to continue to have the extension of time to pay for these loans."

Currently, in-state tuition for a state-sponsored medical school is $6,550 per year, while out-of-state tuition is $21,852.

Statistics show that almost one half of the physicians who borrowed to complete undergraduate and medical school in Texas graduated with more than $30,000 in debt. And one fourth of all medical graduates in the United States will owe between $50,000 and $100,000 upon graduation. The loss of deferment would not only affect loans obtained for medical school but student loans obtained to complete undergraduate studies as well.

TMA's Council on Medical Education and Committee on Rural Health have joined the AMA and others in urging medical students, residents, and other physicians to contact their congressional representatives to oppose the reauthorization bills and to urge that the current provisions for deferments be kept throughout postgraduate training.

At a minimum, the groups are seeking deferments for at least the first 3 years of residency and loan forbearance restored to 10 years regardless of salary or compensation.

Congress was expected to take up the bills early in its 1992 session. ★

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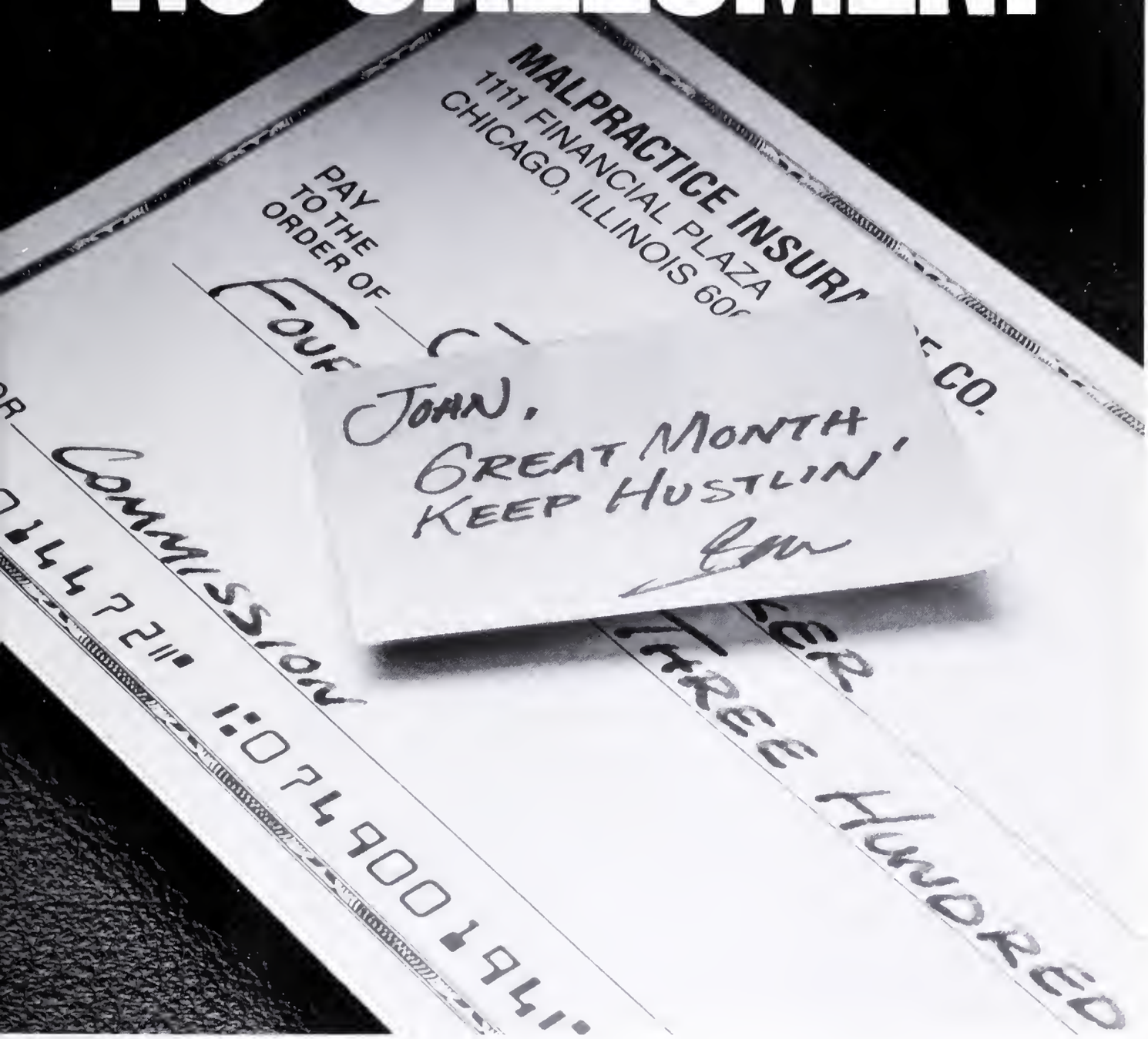

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Public Health

Cancer programs encourage physicians to detect and prevent

TWO WEAPONS HAVE BEEN added to the cancer control arsenal available to Texas physicians.

The programs — The Rio Grande Valley Cancer Prevention & Detection Program and SPOT Your Cancer Risk — are the result of combined efforts by the Texas Academy of Family Physicians (TAFP), Texas Medical Association, and The University of Texas M.D. Anderson Cancer Center.

The two programs share a common goal of making every physician's office a cancer prevention and detection center.

Cancer detection program for men, women

Identifying high risk cancer patients is the focus of the office-based prevention program, SPOT Your Cancer Risk.

Designed to reduce the impact of cancer as a health threat to all Texans, the program is aimed at detecting and preventing lung, breast, colon, cervical, prostate, testicular, and skin cancers.

"The program provides an organized approach to integrate cancer prevention into the family doctor's practice," says Abe Rodriguez, MD, a member of the cancer prevention steering committee for the Texas Academy of Family Physicians and TAFP representative to TMA's Physician Oncology Education Program (POEP) steering committee. The San Antonio family practitioner says the program gives any doctor interested in providing cancer prevention and early detection a systematic approach to incorporating the service into his practice.

Family physicians are encouraged to give comprehensive risk evaluations to all patients. Materials such as a risk questionnaire, office flowchart, chart stickers, patient schedule cards, appointment reminders, and screening flow sheets are included in the program packet.

Dr Rodriguez expects a favorable response to the program because the system was designed to allow the doctor to use the entire system or specific parts depending on the structure of his or her practice.

The POEP funded the development of SPOT, including a pilot study to review its format. M.D. Anderson, POEP, and Texas Medical Liability Trust are now funding the distribution of SPOT to a sample of family physicians. Plans also call for the distribution of SPOT to residents and additional primary care physicians in the upcoming year.

M.D. Anderson will provide the resources to evaluate the program.

For information on SPOT, contact TAFP at (512) 451-8237.

Help for women in the Valley

Due to a high rate of cervical cancer among women in the Rio Grande Valley, M.D. Anderson Cancer Center along with TAFP developed a program specifically designed for that population.

Even though cervical cancer rates are declining nationwide, the numbers remain relatively high in the Rio Grande Valley.

The program focuses on the need for doctors to educate patients about the importance of Pap tests. Once it is determined a Pap test should be conducted, the physician is then able to keep a record of the tests along with future treatment needs based on results. In the event the patient does not have the money for a Pap test and doesn't qualify for financial assistance, then the family physician is encouraged to donate his or her service and the test is then interpreted at M.D. Anderson.

The program involves over 100 members of the Valley Chapter of the Texas Academy of Family Physicians.

Physicians interested in the program may call (800) 235-0296.

Project urges healthy start for mom, baby

CONCERNED WITH THE importance of prenatal care, the Texas Commission on Alcohol and Drug Abuse has funded and created a campaign for expectant mothers and women of childbearing age.

The program, "Baby's First Gift," features a reusable, canvas tote filled with childcare products and bilingual health information designed to warn women about the dangers of prenatal substance abuse. With assistance from the Texas Prevention Partnership (TPP), the Entertainment Industries Council, The Texas Department of

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

AGENDA ON AIDS

Counseling patients who test HIV positive

One of your patients tests positive for HIV. What information must be provided to ensure effective counseling? The AIDS Regional Education and Training Centers for Texas and Oklahoma reminds physicians to tell patients:

- Testing HIV positive does not mean he or she has AIDS.
- The patient should not give up hope and should be aware that treatments can delay the onset of serious symptoms and prolong life.
- The patient has certain responsibilities to prevent further spread of the disease. These include not donating body organs, blood, or semen; practicing safe sex or abstinence; avoiding the sharing of personal hygiene products; alerting physicians and dentists of his or her HIV status. An HIV test should be encouraged for sexual or needle-sharing partners, and female patients should take measures to prevent pregnancy.

Physicians should also be aware that the Texas Health and Safety Code (§81.109) requires that patients be counseled for positive HIV results and stipulates the types of information that must be provided.

HIV infection kills 22,082 people in 1989

The US Department of Health and Human Services reports deaths relating to HIV infection increased 33% in 1989 over 1988 deaths.

- In 1988 there were 16,602 deaths relating to HIV infection.
- The greatest number of deaths for males and females were in the age groups of 25–34 and 35–44 years.
- HIV infection in 1989 was the 11th leading cause of death.

Sources for Agenda on AIDS are the AIDS Regional Education and Training Centers for Texas and Oklahoma and National Center for Health Statistics Monthly Vital Statistics Report (January 7, 1992).

Health, the March of Dimes, the American Lung Association, along with community-based organizations, the tote bags are being distributed through public health clinics. Since community involvement is encouraged, products are donated and collected by local organizations.

"We want to make sure women are seeking prenatal care," says Harvey Weiss, TPP director of field services. "Prenatal care can make a difference."

The program emphasizes good prenatal care with avoidance of illegal drugs to help ensure the birth of a healthy child.

Both Texas Medical Association and the TMA Auxiliary are considering participating in the program.

For information on the program, contact TPP at (512) 480-8953.

Drug-exposed infants: stats reveal extent of problem

- An estimated 50,000 drug-exposed infants are born in Texas every year.
- 11,000 of the 50,000 are low-birthweight.
- $3 billion is spent each year in the United States to treat 100,000 babies exposed to crack during pregnancy.
- More than 375,000 babies will be born in 1992 to substance-abusing mothers.
- Texas ranks 2nd in the United States for the number of live births.
- Texas ranks 3rd for live births to women receiving late prenatal care.

Source: Texas Prevention Partnership.

AMA promotes campaign against family violence

An aggressive campaign against "America's deadly secret" has been launched by the American Medical Association.

Guidelines to assist physicians in identifying and treating victims of family violence will be released beginning in April as part of the Physician's Campaign Against Family Violence.

"The Texas Medical Association is interested in stopping the spread of violence at all levels, particularly family violence, since it appears to be growing," says TMA President Sam A. Nixon, MD, Houston. "TMA and AMA will continue to be in the forefront to prevent injuries, whether mental or physical."

The AMA campaign was to be discussed at a meeting of the TMA Council on Public Health during the Winter Leadership Conference in late February, according to Catherine Edwards, PhD, director of the TMA public health and scientific affairs department.

Four sets of guidelines will be available from the AMA covering child physical abuse, child sexual abuse, domestic violence (violence between intimate partners), and elder abuse.

"It is critical for doctors to have such guidelines — to sensitize us, train us, and aid us in routinely assessing for evidence of family violence," says Robert E. McAfee, MD, vice chairman of the American Medical Association's Board of Trustees. The child physical abuse guidelines will be released first followed by protocols for child sexual abuse.

"Children are the most vulnerable, defenseless, and innocent of all

who are victimized," says Dr McAfee.

Mark Rosenberg, MD, director of the division of injury control for the Centers for Disease Control, believes the problem of family violence is "beyond the reach of the criminal justice system alone" and public health must address the issues and problems.

"The essence of public health is prevention, and it is that very essence that will enable public health to address the issues and problems in a manner that complements the efforts of the criminal justice system," says Dr Rosenberg. "We can focus on changing attitudes that legitimize violence in our society. We can also try to change behaviors like teaching children and adolescents alternate responses to stress and conflict."

US Surgeon General Antonia Novello, MD, says, "Society is too violence tolerant and it has become mainstream.

"We must address the complex problem of a violence-saturated society as a public health issue and combat it in our mass media, in our classrooms, and at home," says Dr Novello. "Domestic violence is a cancer that gnaws at the body and soul of the American family." ★

Facts and figures on domestic violence

- 612,738 Texas women were physically abused by male intimate partners in 1989.
- 125 Texas women were killed in 1989 by their husbands, ex-husbands, common-law husbands, or boyfriends.
- 56 Texas family violence shelters answered 125,068 hot line calls in 1990.
- 10,394 women and 14,996 children were housed in Texas shelters.
- 9,619 battered Texas women not being sheltered were counseled in 1990.
- 95% of the victims are women.
- 3 to 4 million American women are battered each year by their husbands or partners.
- 37% of obstetric patients are physically abused during their pregnancies.
- Texas Family Violence Hotline: (800) 252-5400.

Sources: Texas Council on Family Violence and National Woman Abuse Prevention Project.

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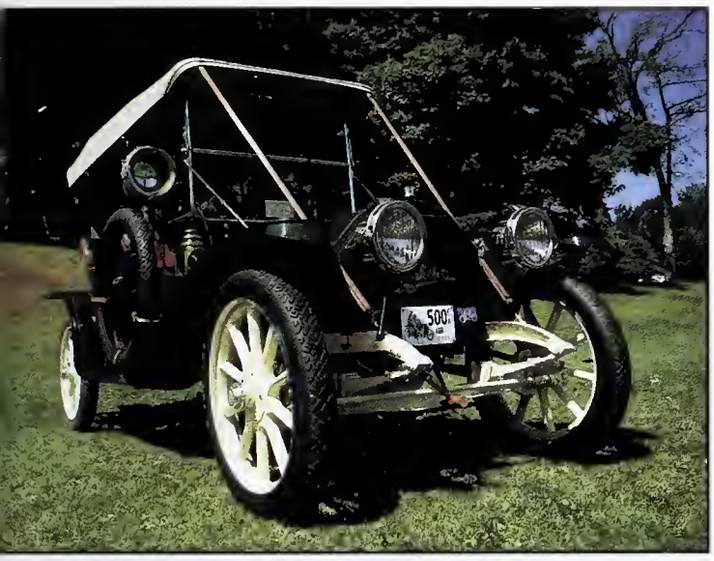

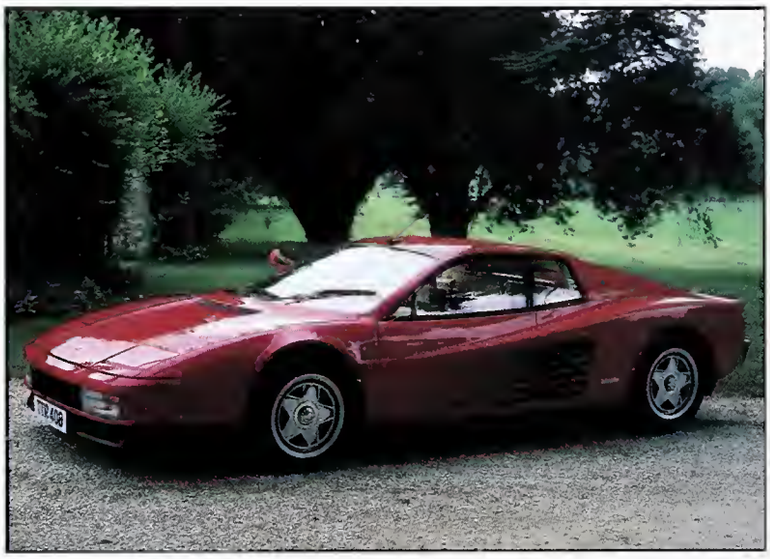

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Reimbursement Revolution

Medicare's RBRVS System

As revolutions go, it was relatively short.

It began as a bright idea, was developed into a scientific theory, bandied about in the political arena, filtered through the legislative process, run through the regulatory maze, and tossed, somewhat unceremoniously, on your doorstep, all in a few short years.

By Mark Richardson
Associate Editor

"It" is the Resource Based Relative Value Scale (RBRVS), now being phased in by the Health Care Financing Administration (HCFA) to reimburse physicians for care provided to Medicare patients. After 4 years of discussion and planning, the controversial RBRVS fee schedule went into effect January 1 as a sort of national experiment — put in place without any kind of trial run.

The program emphasizes both cost control and payment reform. The system generally increases fees for family practice and internal medicine, while cutting back — sometimes sharply — on those available to many specialists. Texas physicians, almost without exception, have come out on the short end of the stick.

And though it is still too early to document what effect RBRVS is having on physicians' practices, there is no shortage of speculation about what it will bring for physicians, their patients, and the American system of health care.

In attempting to evaluate just what the Medicare RBRVS fee schedule will ultimately mean to physicians, it might be helpful to paraphrase a line from Oscar Wilde: "There are but two tragedies in life — not getting what one wants, and getting what one wants."

Almost everyone — physicians included — agreed that the pre-1992 Medicare payment system was unfair, cumbersome, and badly in need of change. It also was getting more expensive and less effective each year. Family physicians, who were providing the majority of basic services, were losing money on virtually every patient.

So after several years of study, physicians and the federal government tentatively agreed to develop the RBRVS system in an attempt to bring fairness to reimbursement and to balance fees to encourage primary care. And though the government set about to pursue those lofty goals, by the time the bureaucracy at HCFA had finished shaping the new system, many physician leaders say it much less resembles the noble experiment in payment reform it was meant to be than a thinly disguised package of federal budget cuts and price controls.

And that may remind you of Oscar Wilde's description of the perfect cynic (read: bureaucrat) as "one who knows the price of everything, and the value of nothing."

WAITER, IS THIS REALLY WHAT I ORDERED?

According to Harold Whittington, a Dallas-based medical payment consultant, many physicians who supported RBRVS in theory are considerably less enthusiastic about it in practice.

"I don't think the people who were encouraging payment reform — mainly the doctors who furnish medical services — will receive as much of Medicare's generosity as they thought they would," he said. "I haven't seen anybody yet who has bowed three times and thanked Medicare for this new system. The very people it is designed to help are just as skeptical of it today as the people who had something to lose by it."

Glen Journeay, MD, PhD, an Austin family physician, said that despite the system's emphasis on primary care and diagnostic procedures, he doesn't see himself getting rich from RBRVS.

"The big money in medicine is still coming from the things that you do to people, the surgical procedures and things like that, which I don't do," he said. "And although they have offered us more money for cognitive services, it really does not improve our incomes very much," he said.

Louis Goodman, PhD, TMA's director of medical economics, stressed that the new system has its share of problems.

"The RBRVS system was born as a theory and it moved very rapidly, warts and all, to become the law of the land because the alternatives (DRGs, national health insurance, across-the-board cuts) were unacceptable," he said.

"Now that it's law, it's going to be a few years before we really see what impact it has, but it's going to have a much broader impact than just cost. It's going to affect the care that's delivered, who gets the care, and how much money is available for technology to provide that care," said Dr Goodman. "What does that mean to patient care? That means there will be a lot more access to primary care services but there's a potential for some real dislocation in surgical services. There may be, as a result of this system, fewer physicians going into those areas that are underpaid. There may be waiting lines to get into services. There may be a change in the style of practice."

David Marcus, PhD, TMA's director of health-care financing, said the reality of RBRVS is going to upset many.

"I think that what we're going to see is a lot of anger, a lot of disappointed expectations. In a time of politically dictated budget controls, RBRVS will at best put a floor under payments for primary care. I'm very skeptical about projections showing substantially increased income for anybody," he said.

Dr Marcus added that while he thinks RBRVS won't be a bonanza for primary care physicians, its efforts to control Medicare expenditures will fare much worse.

"Everybody has this fantasy about price controls that when you enact them, everything is going to be exactly the same as it was, except that whatever it is you want will cost less," said Dr Marcus. "But that's not true. They didn't work for energy. Across-the-board controls failed in the 1970s. Rent controls have devastated the housing market in New York City.

"Despite the many times we've been kicked as a society because of trying price controls, we still haven't learned that they don't work," he said.

REACHING FOR THE SKY

The driving force behind the search for a new physician payment system was the skyrocketing costs of the Medicare program and the inequities of the past.

Between 1966 and 1987, Medicare enrollments grew 62.6%. In the same time period, Medicare Part B program disbursements grew an amazing 2,320%. And the trend is expected to continue. Gail Wilensky, PhD, administrator of HCFA, expects payments to physicians to climb from $27 billion in 1991 to nearly $45 billion in 1996, a jump of 63%.

"When you stage this kind of reform, this kind of major change, there is a significant political context that you can't avoid," said Dr Marcus. "And, make no mistake, the political context of this is cost reform. We have to hear that message now in order to have realistic expectations about what's going to happen over the next 4 to 5 years."

And after the dust cleared, just what magic formula is HCFA using to accomplish both payment reform and cost cutting?

After more than a decade of study by Harvard University researchers, the equation is a mix of variables based on the assumption that it's possible to determine the relative worth of each service performed by physicians. Relative Value Units (RVUs) were established for each service as a way of deciding how much more "work," risk, overhead costs, one procedure represents than another. The balance of the equation includes regional variables (Geographic Practice Cost Indexes, GPCIs, also called "gypsy") and the much-discussed conversion factor, which converts RVUs to dollars. (See box, next page.)

All in all, it is a fairly straightforward way of calculating your payment. But determining the value of the variables that influence those final payments — RVUs, GPCIs, and the conversion factor — has proved to be a major point of contention between medicine and the government.

WE'RE NOT IN KANSAS ANYMORE

When organized medicine — meaning the AMA, its state affiliates such as TMA, and various specialty societies — endorsed the concept of changing Medicare payments to a relative value scale in the 1980s, they felt they were presenting the federal government with a positive framework for reform. Physicians had come to the conclusion that such a system was fairer than the alterna-

tives available at that time.

HCFA enlisted William Hsaio, PhD, professor of economics and health policy at Harvard University School of Public Health, to lead a team of researchers in developing the system. That group, in publishing its research in October 1988 in the *Journal of the American Medical Association*, identified the cost of physician services as a major factor in the high cost of health care in the United States.

In the article (*JAMA* 1988;260: 2347–2353), Dr Hsaio identifies the doctor as the key decision-maker in the health-care delivery system, noting that 80% of all health-care costs relating to diagnosis, prescription, and treatment of disease are affected by decisions made by physicians.

The study states that market forces have not been permitted to identify the price of physicians' services or to control these costs through patients' decisions. The study concludes that the market for health-care services is therefore distorted and that government policymakers must determine the true price of health-care services through arbitrary measurement of the resource costs of providing them.

Meanwhile, doctors and the federal government hammered out a "physician reimbursement agreement," which outlined the ground rules under which the RBRVS system would be developed by HCFA. The result of HCFA's interpretation of that agreement was published in the *Federal Register* June 5, 1991, as preliminary regulations.

Organized medicine's reaction to those rules was unmistakably hostile.

"Totally unacceptable," AMA Executive Vice President James S. Todd, MD, said at the time. "They have outraged the physicians of America."

What angered physicians most was not so much the payment system or laws under which it was devised, but the way HCFA was interpreting them. The agreement had called for a "budget neutral" changeover to RBRVS, with no changes in the total amount of money paid to physicians during the first 5 years of the system.

HCFA's preliminary calculation of total spending on physician services came in at $6 billion less by 1996 than if there had been no change in the law. The proposed conversion factor was 16% lower than expected at $26.87. Several regulatory issues concerned physicians, as well.

More than 95,000 physicians responded angrily to HCFA's proposed regulations, and by the time the final regulations were issued November 25, 1991, the numbers had improved considerably. The conversion factor was upgraded 13% to $31.001 for 1992, and several other changes made the package more palatable.

The AMA's James Todd, MD, sounded a conciliatory note, calling the changes "significant improvements." But the final rules still fell short of what the AMA wanted. "Fundamental problems remain," said Dr Todd.

MEANWHILE, BACK AT THE RANCH (*or*, GPCIS, TRAMPS, AND THIEVES . . .)

If things were better but not great nationwide, they didn't see much improvement in Texas when the final regulations were issued.

According to Mr Whittington, Texas physicians get hit with a double whammy under the RBRVS system: Flawed GPCIs are keeping fees

How HCFA calculates your Medicare payment

The Resource Based Relative Value Scale (RBRVS) method of determining Medicare fee payments is derived through a formula consisting of three main elements: a Relative Value Unit (RVU), a Geographic Practice Cost Index (GPCI, pronounced "gypsy" by some), and a national dollar Conversion Factor (CF).

The system began January 1, 1992, and will be phased in incrementally until January 1, 1996, replacing the previous system of individual physician profiles based on "usual, customary and reasonable" charges.

The payment formula looks like this: **[{RVUws x GPCIwa} + {RVUpes x GPCIpea} + {RVUms x GPCIma}] x CF = payment.** RVUs are set on a national scale; GPCIs, which are calculated as a percentage of a national average, modify these national values based on regional economic factors. The national conversion factor is set based on the amount of funds available.

According to information published in the *Federal Register*, the four parts of the equation include:

- The relative value of the physician's work (time, intensity, risk) for the service performed **(RVUws)** is multiplied by the geographic cost index value reflecting one fourth of the geographic variation in physician work **(GPCIwa)**.
- The relative value of the expense (billing, rent, office overhead, etc) for the service **(RVUpes)** is multiplied by the geographic cost index for the practice expense applicable in the geographical fee schedule area **(GPCIpea)**.
- The malpractice relative value units for the service **(RVUms)** are multiplied by the geographic cost index value for malpractice expense applicable in the fee schedule area **(GPCIma)**.
- The sum of the geographically adjusted relative values is multiplied by a uniform national conversion factor **(CF)** to determine the payment.

For example, a physician in Tyler repairing an elbow fracture (CPT code 24583) would calculate the fee based on RVUs of: Work = 9.38, Expense = 8.71, and Malpractice = 1.41. The GPCIs for Tyler are: Work = 0.984, Expense = 0.931, and Malpractice = 0.504. The conversion factor for 1992 is $31.001.

Payment would be calculated: **[{9.38 x 0.984} + {8.71 x 0.931} + {1.41 x 0.504}] x $31.001 = $559.57.** (Payment does not include any modifiers or adjustments, which may vary from physician to physician.)

TMA develops action plan to help physicians cope with RBRVS

In 1992, thanks to the advent of RBRVS, final CLIA regulations, revised HCFA claim forms, and a host of other obstacles from the federal government, Texas physicians face an unprecedented level of regulatory overload.

It is no longer time to prepare for the changes coming to medicine; it is time to learn how to cope with them.

The physician leaders and staff of the Texas Medical Association have devised a highly focused "hands-on" strategy to help members through what promises to be a difficult period.

TMA President Sam Nixon, MD, said the association is going into high gear to help its members in 1992.

"TMA has led a vigorous effort to make the RBRVS responsive to the needs of Texas physicians through personal visits, telephone calls, and the outpouring of letters from members, which did indeed get HCFA's attention," he said. "These activities will continue in order to make the RBRVS responsive to the needs of Texas physicians."

The plan concentrates on five main areas:

- **Individualized assistance focusing on coding and claims-filing issues.** Two additional staff members have been hired to assist members with problems relating to Medicare, coding, and other aspects of federal regulations.
- **Practice management seminars that address the changes in Medicare and other programs.** A series of workshops on the new coding system were held in January and February. Several more rounds of seminars are planned around the state beginning in April on various payment reform issues.
- **Intensified efforts to communicate information about Medicare RBRVS and other programs.** TMA will continue the flow of information to members through publications such as *Texas Medicine*, *Action* newsletter, and the TMA speaker's bureau.
- **Easily useable reference materials on Medicare.** *The Coding Tree* is designed for medical offices to use as a training resource and reference guide for CPT coding. Also available during the year will be updated Medicare fee schedules, *The Medicare Maze*, second edition, and *A Texas Physician's Guide to Medicaid*.
- **Continued vigorous pursuit of legislative and regulatory relief for problems and inequities in the RBRVS system.** TMA has identified and documented problems in the 32 GPCIs in Texas, which all fall below the national average and plans to pursue, through legislation in the current session of Congress, changes in the geographic modifiers.

low, he said, but Texas' historical Medicare rules are also having a negative effect.

"The GPCI is just like a thermostat in a room: It determines whether payment goes up or down," Mr Whittington said. "The nationwide fee schedule was compromised in Texas. I don't know of a single locality in the state of Texas that gets the nationwide fee schedule. In every locality, including Dallas and Houston, the GPCIs come in at slightly less than the nationwide average, so we get hit everywhere we look. We're not even getting a 'Middle America allowable.'"

GPCIs are predicated on 100% of the national average, he said. When one is set at 0.9782, that means for that particular component, you are paid 97.82% of the nationwide average. "You won't find a single component with the exception of one or two obscure things where the Texas GPCIs exceed 100%," he said.

"Also, Texas physicians got hurt a lot more than the average practitioner in other states because we had very soft application of the Medicare rules. Texas (historically) had some of the most generous policies," said Mr Whittington. "For instance, Medicare in Texas did not include any office care in the global surgical fee. Ninety percent of the other states did.

"So when Medicare says that under the RBRVS up to 90 days of follow-up care, whether it's in the office or hospital, is included in the surgical fee, this meant nothing to 90% of the states outside of Texas because that's what they were already doing to begin with. It had a tremendous impact on Texas physicians because we were permitted from the very minute a person was discharged from the hospital or ambulatory surgery clinic to start charging those office visit follow-ups. It hurt Texas physicians a lot more because our rules were softer," he said.

TMA's Lou Goodman agrees that the GPCIs need a lot of work.

"What we want is for HCFA to use accurate information in determining the GPCIs," he said. "There are three pieces of the equation: the value of your time, the value of your overhead, and the value of your liability. And we have evidence that their numbers are way off, particularly on the liability part.

"Our evidence shows that in Texas, the index they created is lower than in other states that have lower professional liability premiums. The index should be directly related to the premiums, so we're going to try to convince them to use good data," said Dr Goodman.

He added that HCFA is not taking into consideration the unique population distribution in a state the size of Texas.

"Texas not only has large urban cities but it also has a large rural population," he said. "If the objective is to expand access to services for everyone, especially the needy in the rural areas, having disincentives like the GPCIs works against that."

SLIDING DOWN A SLIPPERY SLOPE

Whereas under the RBRVS system, family practice and general practice physicians will see an increase in payments of about 28% by 1996, most specialists see their numbers going in the opposite direction.

And while this was not an unexpected trend, many are angry that the cuts have been much deeper than originally anticipated and negotiated with HCFA.

Dermatologists such as Fred Castrow, MD, Houston, say they have received a raw deal from the federal government.

"HCFA has violated the physician reimbursement agreement that they had with medicine," he said.

He cited the example of how HCFA implemented two new series of CPT codes for the removal of malignant and benign lesions that were not mentioned at all in the proposed regulations.

"The reimbursement values that HCFA has assigned to these codes are less than what the podiatrist is being reimbursed for paring corns. That is violating the intent of fair treatment of physician reimbursement," said Dr Castrow.

Other specialties face even deeper cuts. According to HCFA statistics, by 1996, anesthesiologists will see a 27% cut in payments per service, radiologists will be cut 22%, gastroenterologists by 18%, and cardiologists will be cut by 17%.

For 1992, the first year of RBRVS implementation, the average fee for a total hip replacement drops from $2,105 to $1,772. A total knee replacement drops from $2,241 to $1,886. A coronary artery bypass average fee drops from $3,178 to $2,726.

Those are national averages: With lower GPCIs, Texas specialists face even lower fees.

Physician fee schedule impact by specialty

Percent change in allowed charges for the new fee schedule relative to customary, prevailing, and reasonable rates.

	1992 change in:		1996 change in:	
	Payment/ service (%)	Payments (%)	Payment/ service (%)	Payments (%)
All specialties	-3	0	-6	0
Family practice	15	16	28	30
General practice	17	18	27	29
Cardiology	-9	-3	-17	-8
Dermatology	-1	0	0	2
Internal medicine	0	1	5	7
Gastroenterology	-10	-4	-18	-9
Nephrology	-6	-2	-9	-5
Neurology	-4	-2	-4	-2
Psychiatry	-2	-1	3	5
Pulmonary	-3	-1	-2	0
Urology	-6	-2	-8	-4
Radiology	-10	-4	-22	-11
Anesthesiology	-11	-4	-27	-14
Pathology	-10	-4	-20	-10
General surgery	-8	-3	-13	-7
Neurosurgery	-10	-4	-18	-9
Ophthalmology	-11	-4	-21	-11
Orthopedic surgery	-8	-3	-11	-5
Otolaryngology	2	3	3	5
Plastic surgery	-8	-3	-13	-6
Thoracic surgery	-14	-5	-21	-14
Clinics	-1	0	-1	1
Optometry	20	21	41	43
Chiropractic	12	13	26	28
Podiatry	6	7	14	16

Source: Health Care Financing Administration

EVERYBODY'S PROBLEMS

Of course, not all of the problems with RBRVS are limited to Texas physicians. Nationwide, organized medicine is putting on a full court press to alter the RBRVS system that may ultimately be more intense than its earlier efforts in 1991 to shape the final rules.

The AMA House of Delegates, meeting in December in Las Vegas, issued a strongly worded statement outlining its agenda on RBRVS. The AMA delegates did not mince words about their feelings: "The RBRVS-based Medicare physician payment schedule requires substantial improvements in many of its key elements, and the AMA cannot endorse this new system until substantial improvements are made."

Among the improvements the AMA wants are:

- An extension of HCFA's grace period on the use of new CPT visit codes until at least April 1, 1992, and then limiting the use of the codes to educationally oriented profiling and review until July 1, 1992. (At this writing in mid-January, HCFA had extended the grace period through February 29.)
- Prevention of any further reductions of the current Medicare policy regarding limiting charges.
- A second Medicare participation decision period between June 1 and July 1, 1992, to allow physicians to reconsider the decisions they were forced to make in December 1991 based on very limited information.

RBRVS physician fee impact by selected states

Percent change in allowed charges for the fee schedule relative to customary, prevailing, and reasonable rates.

	Year 1 (1992) change:		Year 5 (1996) change:	
	Payment per service (%)	Payments (%)	Payment per service (%)	Payments (%)
All states	-3	0	-6	0
California	-5	-1	-14	-4
Colorado	2	4	9	11
Florida	-8	-2	-17	-5
Georgia	-3	-1	-6	-2
Hawaii	-8	-2	-16	-5
Idaho	0	2	6	8
Illinois	-3	-1	-5	-1
Louisiana	-4	-1	-7	-2
Mississippi	1	3	12	14
New Mexico	-3	-1	-9	-3
New York	-4	-1	-8	-2
Oklahoma	-2	0	-3	1
Texas	-4	-1	-11	-3
Wyoming	1	3	8	10

Source: Health Care Financing Administration

- Replacement of the current flawed proxy data basis for Medicare's GPCIs with current data that reflect actual practice overhead costs.
- Relief for such inequities as lack of any payment for interpretations of EKGs, discriminatory payment reductions for "new" physicians, surgery, and "new" patients, and a 50% copayment for mental illnesses.

As a part of its plan to bring about the changes, the AMA will study the consistency and fairness with which the RBRVS system is implemented; establish a program to monitor changes in patient access, physician practice patterns, and errors in carrier payment schedules; seek adequate funding for Medicare carriers as they implement RBRVS; work with HCFA and specialty societies to clarify the new global payment policy; and study and report on the "behavioral offset" and "baseline adjustment" with an emphasis on the history of the use of these adjustments.

Another major issue regarding RBRVS that concerns organized medicine is the chance that the system will eventually become a standard for medical reimbursement by all insurers.

In fact, members of the TMA House of Delegates passed a resolution at their interim meeting last November stating their strong opposition to RBRVS being used for anything other than Medicare and Medicaid reimbursements.

But such sentiment may only be wishful thinking. Private insurers, says Dr Goodman, have already begun to embrace the system, and it may only be a matter time before they adopt it or a similar method.

"I think that most of the insurers, the big-time insurers, will be looking at it," he said. "Since Medicare is administered by Blue Cross/Blue Shield in Texas, I would think they would be one of the first to move to that kind of system if it proves itself," he said, adding that most insurers will wait and see how well the system works before jumping on board.

"Looking down the road, I think that within 3 to 5 years if the system pans out, if it's simpler, if it reduces costs, and if it expands primary care, it will be the direction that most of the insurers will go," said Dr Goodman.

AN ISSUE OF FAIRNESS

According to almost everyone connected with the process, the development of the RBRVS system, whatever its flaws, will result in a payment system that is intrinsically fairer than the previous system.

How fair depends on whom you ask.

HCFA's Gail Wilensky flatly states that "the fee schedule creates a fairer and more rational physician payment system."

Others agree, with reservations.

"If you define the problem with Medicare as an inherent imbalance in payments, where procedures were compensated at a much higher level than the cognitive services, then by all means it is a fairer system," said Mr Whittington. He said the original Medicare system of "reasonable charges" often produced an inherently unreasonable set of charges when physicians artificially increased the price of a procedure. "HCFA wanted to find a 'level paying field' and put a process in effect that would eliminate these inherent inequities.

"If that was one of the predetermined purposes of RBRVS, it worked," he said. "If it was designed to cut the overvalued services, they did a marvelous job of that."

Dr Journeay, chairman of the *Texas Medicine* Editorial Committee, said any effort to balance out the payment system was a good one.

"Historically, in the mid-1970s, the government asked us to hold our fees down, and we held our fees down, and then they put a freeze on our fees. We never really recovered from all that," he said, adding that the amount he can charge for a regular office visit has only gone up $1, from $23 to $24 with RBRVS.

"I guess if you added it all up, that may mean another $100 to my annual income," he said.

All in all, though, he thinks the system takes a fair approach to determining fees.

"I know that the relative cost of

Fee schedule payments vs 1991 average payments

(For selected high volume physicians services.)

	CPT code	1991 average payment ($)	1992 average payment ($)
ffice visit, new, level 3	**99203**	**40**	**47**
ffice visit, established, level 3	**99213**	**26**	**30**
ffice visit, established, level 4	**99214**	**39**	**45**
ospital visit, initial, level 2	**99222**	**77**	**88**
ospital visit, subsequent, level 3	**99233**	**47**	**55**
otal knee replacement	**27447**	**2,241**	**1,886**
sertion of heart pacemaker	**33207**	**811**	**694**
oronary arteries bypass	**33512**	**3,178**	**2,726**
iagnostic colonoscopy	**45378**	**337**	**286**
emoval of gallbladder	**47600**	**743**	**626**
ostatectomy	**52601**	**981**	**824**
emove cataract, insert lens	**66984**	**1,342**	**1,151**

urce: Health Care Financing Administration

medical care has gone up over the years more than everything else has, but I can tell you from talking to my friends in family practice and in my own experience, our purchasing power has gone down drastically over the last 10 years because we have not been allowed to raise our fees to the same extent that our overhead has gone up."

Even though he is faced with a 20% drop in most of his fees, internist Robert Donald, MD, Houston, feels that RBRVS is a better system than before.

"The old limiting charges, which were based on archaic numbers developed back in 1974, were so skewed from the very beginning that all of the yearly updates that came through were still skewed," he said. "These are the first codes that I think have some intelligence behind them as far as how they progress according to workload."

But what about that 20% he'll be losing?

"It just so happens that I was enjoying a better level of reimbursement under the old system," Dr Donald said.

Denton Cooley, MD, Houston thoracic surgeon, said he also sees it as an improvement.

"I know a lot of effort has gone into developing a pay scale that is reasonable," he said. "By and large, I think the fees are low but they are reasonably fair in the present situation. I don't know of any alternate method that would be an improvement, unfortunately.

"I know our specialty (cardiovascular surgery) has been cut back more than some others, but I think we will be able to continue as we are going. There are ways to compensate for the cuts," he said.

Some still hold that market forces are a better way to set fees. TMA's David Marcus said the system is a major disappointment to many physicians.

"You can look at payment reform as having a text and a subtext. The text is: payment to physicians has been irrationally distributed and therefore we will devise a resource based method that is rational," he said.

"The subtext of it, though, is that we need to have some kind of rationality in order to control the payment system," he added. "Once you have the system in place, two things can happen: Medicare can greatly reduce the value of what is paid across the state or country for any particular service by adjusting the RVUs and claiming the service is "overvalued," or the government can adjust the conversion factor and reduce payments to everyone for everything. The tools for controlling expenditures are readily available by just playing around with a relatively small set of numbers."

A glossary of terms for RBRVS

Baseline adjustment — An across-the-board percentage of funds deducted by HCFA in the overall numbers for RBRVS to account for an anticipated increase in claims. This figure, unlike a behavioral offset, is based on several different factors and not solely on the assumption that physicians will increase utilization to make up for losses under RBRVS.

Behavioral offset — A percentage of all physicians' reimbursements that is held back by Medicare, based on the assumption that under payment reform, physicians will increase the number of procedures they perform to compensate for the loss of revenue. Unlike managed care behavioral offsets, in Medicare there is no opportunity for physicians to regain all or part of this amount. This controversial factor was not included in the 1992 final regulations, but could reappear in subsequent years.

CF — The conversion factor is a number, expressed in dollars, by which the sum of the geographically adjusted RVUs is multiplied to obtain the payment.

CPT codes — The visit and consultation codes contained in the book *Current Procedural Terminology* (1992), published by the AMA, constitute the system for describing physician services that must be used on all Medicare claims.

Global surgical fee — A fee covering a surgical procedure, including the day prior to surgery, the surgery itself, and the postoperative period as specified in the fee schedule.

GPCI — The geographic practice cost indices are numbers that modify the RVUs based on the practice costs in a specific geographic region.

HCFA — The Health Care Financing Administration, the branch of the Health and Human Services department of the federal government that administers the Medicare program.

Physician's Payment Profile — A set of records kept by HCFA that tracked Medicare claims filed by participating physicians, used under the old Medicare payment system to determine several factors in reimbursement.

RBRVS — The resource based relative value scale is a system used by the federal government to determine fees for Medicare services based on the relative value of each service.

RVU — A relative value unit is the number assigned to each service performed that determines the value of that service based on work involved, the office overhead costs of the service, and the malpractice costs of the service.

UCR — The "usual, customary, and reasonable" charge for a physician's service. This method was previously used to determine a physician's reimbursement rate before the advent of RBRVS.

Survival checklist for coping with RBRVS

The Medicare RBRVS fee system is bringing major changes to your practice. Here are some items you will need to have and to remember to deal successfully with the new system:

- ☑ **Updated Medicare fee schedules.** Physicians who purchased the Medicare fee schedules from TMA may, upon request, receive an updated version using HCFA's $31.001 conversion factor and other changes made in the final regulations. Members who have not already purchased a copy may order one for $49. (Nonmember cost is $98.)
- ☑ **Current Procedural Terminology (1992).** The system for coding claims has changed totally. The new CPT evaluation and management codes system assigns values to more than 7,000 medical procedures and services. "Crosswalking" codes by simply substituting new codes for old is not recommended, since many of the codes in the new system do not have direct translations from the old system. (See "Mastering new CPT codes may mean increased Medicare reimbursement," *Texas Medicine*, December 1991, p 18.)
- ☑ **UPINs.** All referred or ordered claims for services must list the referring physician's name and his or her Unique Physician Identification Number (UPIN) as assigned by HCFA.
- ☑ **Revised HCFA-1500 claim forms.** After May 1, 1992, Medicare carriers will no longer be allowed to accept "superbills" or any other nonstandard claim forms. All claims must be filed on a standard HCFA-1500 form, revised to reflect the new CPT codes for 1992.
- ☑ **The Coding Tree.** TMA has produced and published a booklet translating the CPT 1992 system into a series of flowcharts that medical offices can use as a training resource and reference guide. *The Coding Tree: Using the New Evaluation and Management Codes* is available for $49 to TMA members, $98 for nonmembers. (See ad on p 54.)
- ☑ ***The Medicare Maze.*** A second edition of this highly successful publication, which will focus on payment reform issues, is expected out by fall of 1992. Watch for information on cost and how to order in subsequent issues of *Texas Medicine* and *Action*.
- ☑ **TMA-sponsored workshops.** TMA is planning several series of workshops around the state in 1992 to assist physicians in unraveling the complexities of RBRVS and the CPT coding system. Watch the mail for announcement of dates and locations near you, or check *Texas Medicine* and *Action* each month for listings.
- ☑ **Call TMA toll-free.** TMA is adding extra staff to assist members with questions and problems they have in dealing with Medicare. Members may call **(800) 880-1300** during normal business hours and talk with experts on claims coding, practice management, medical payments, and others who can help solve your Medicare payment problems.
- ☑ **TMA's Hassle Factor Log.** TMA wants to know what problems physicians are facing with Medicare, managed care, or any other issue regarding medical payments. When an insurance carrier hassles you, jot it down on a Hassle Factor Log form (see p 47) and mail it to TMA. TMA staff members regularly work with carriers to assist in clearing up problems.

Dr Marcus adds that there is also a political context, "which is that we can't afford the Medicare system we've designed and this is a way of not confronting that issue, by playing games with the existing system."

A SMALL PART OF THE BIG PICTURE

The RBRVS payment system, for all the ruckus it has caused, may simply be the first salvo in a long, heated battle yet to come over reform of the health-care system in the United States. While it addresses one sector of the system — Medicare — many other issues are set to join the fight, particularly in a presidential election year.

The Democratic Party and its several presidential candidates see health-care reform as a cornerstone of the party platform, an issue they hope to ride into the White House in 1992. President Bush countered with his own health-care proposal presented in early February.

What all this attention to the health-care system ultimately means to the physician is an unprecedented amount of interference with the way he or she practices medicine.

"I think the practice environment for doctors is a lot more difficult now than say, 10 years ago," said Dr Goodman. "If you add up all the reviewers, the insurance companies and the government, there's got to be at least one person, maybe two, looking over the shoulders of every physician in this country to see whether they did things right. It's a major challenge that doctors face."

He adds that such an environment will make it difficult for physicians to practice.

"I think that the number of physicians saying that medicine is fun will continue to decline, and the overall attitude of physicians will be colored by the emphasis on cost and the emphasis on regulators looking over their shoulders," he said.

"Physicians have never before been faced with so many burdensome intrusions in the way they practice. Our job is to educate the physician and to fight to make the system as rational as possible," he said. "We're going to stay in this fight until we win it." ★

Zantac® Tablets

ranitidine HCl/Glaxo 150 mg tablets bid

WHEN ACID REFLUX ERUPTS

Please see Condensed Brief Summary of Prescribing Information on adjacent page.

Allen & Hanburys
DIVISION OF GLAXO INC.

Glaxo/ROCHE

Glaxo Pharmaceuticals™
DIVISION OF GLAXO INC.
Research Triangle Park, NC 27709

Zantac® 150 Tablets
(ranitidine hydrochloride)
Zantac® 300 Tablets
(ranitidine hydrochloride)
Zantac® Syrup
(ranitidine hydrochloride)

CONDENSED BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy and is maintained throughout a 6-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to Zantac® administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25°C (39° and 77°F). Dispense in tight, light-resistant containers as defined in the USP/NF.

September 1991

Glaxo Pharmaceuticals™
DIVISION OF GLAXO INC.
Research Triangle Park, NC 27709

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ZA2407 Printed in USA January 1992

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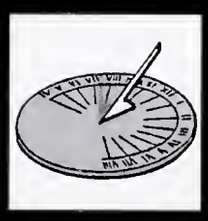

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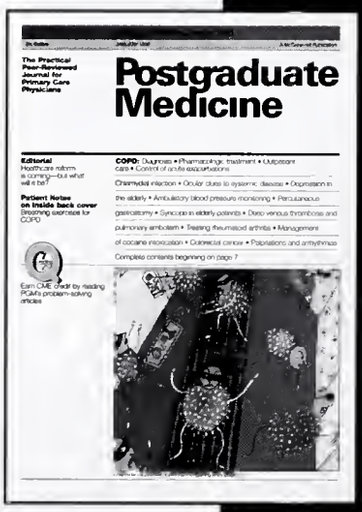

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What's In, What's Out in Medicare.. A Discussion With the Experts

Find the latest on RBRVS and improving third-party reimbursement

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- J. Michael Hudson, Deputy Administrator, Health Care Financing Administration
- Harold Whittington, medical practice consultant

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TMA HASSLE FACTOR LOG

Physician or clinic name _____ **Date** _____

Contact person _____ **Title** _____

Address _____ **Phone number** _____

Company/individual/agency causing hassle _____

Brief description of hassle _____

_____

_____

_____

_____

Is this the first time this problem has occurred or is it a recurring problem? ☐ First Time ☐ Recurring Problem

Subject of hassle:

- ☐ Medical necessity review
- ☐ Quality review
- ☐ Length of stay dispute
- ☐ Precertification of services
- ☐ Referral
- ☐ Problem with terms of HMO/PPO contract
- ☐ Request for information about a patient
- ☐ Denial of payment
- ☐ Reduction of billed charges
- ☐ Recoding of services
- ☐ Other _____

Did this hassle cause the physician or staff to take any of the following actions?

- ☐ Make telephone call(s) How many? _____ Time spent on phone_____
- ☐ Write letter and/or narrative report
- ☐ Resubmit claims
- ☐ Seek outside assistance. If so, from whom?_____
- ☐ Retrieve and review office medical records
- ☐ Retrieve and review hospital medical records
- ☐ Copy and send medical records, progress notes or operative report(s)
- ☐ Consult with colleagues

Can you estimate the total time involved in dealing with this hassle? Staff time _____ Physician time _____

May TMA contact you for additional information? ☐ Yes ☐ No

Please add any additional information you think would be helpful in documenting the nature of this hassle and/or its impact on your medical practice.

_____

_____

_____

_____

Return completed form to TMA Department of Health Care Financing, 401 W 15th St, Austin, TX 78701.

Law

HIV-infected health-care workers: Texas law

Donald P. Wilcox, JD
TMA General Counsel

EVEN THOUGH THE TEXAS Medical Association House of Delegates approved guidelines for HIV-infected health-care workers, physicians must be aware that state law goes beyond association recommendations.

House Bill 7, passed by the Texas Legislature in 1991 during a called session, covers a variety of areas relating to testing, exposure-prone procedures, counseling, and universal precautions (1). An article on TMA guidelines appeared in the January 1992 issue of *Texas Medicine*.* An earlier article discusses the Human Immunodeficiency Virus Services Act, passed by the 71st Legislature in 1989.†

A review of House Bill 7

1. "Universal precautions" as defined by Centers for Disease Control must be adhered to by health-care workers.
2. Health-care workers who perform exposure-prone procedures should know their HIV antibody status, and those workers who do not have serologic evidence of immunity to hepatitis B virus from vaccination or from previous infection should know their HBsAg status and, if that is positive, should also know their HBeAg status.
3. Testing of HIV antibody status must comply with Chapter 81, subchapters C, D, and F, of the Texas Health and Safety Code (concerning reporting of reportable diseases, investigating same, and testing for HIV, including informed consent, confidentiality, and required counseling).
4. "Exposure-prone procedure" is defined to include a specific invasive procedure that poses a direct and significant risk of transmission of HIV or hepatitis B virus, as designated by a health professional association or health facility.
5. An "invasive procedure" means:
   A. a surgical entry into tissues, cavities, or organs; or
   B. repair of major traumatic injuries associated with any of the following:
      i. an operating or delivery room, emergency department, or outpatient setting, including a physician's or dentist's office;
      ii. cardiac catheterization or angiographic procedures;
      iii. a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or
      iv. the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.
6. Health-care workers with exudative lesions or weeping dermatitis must refrain from all direct patient care and from handling patient equipment and devices used in performing invasive procedures until the condition resolves.
7. Educational institutions and vocational schools shall provide instruction on universal precautions.
8. Health-care institutions must establish procedures for monitoring compliance with universal precautions.
9. Except as provided below, a health-care worker who is infected with HIV or hepatitis B virus and is HBeAg positive may perform an exposure-prone procedure only if the health-care worker has sought counsel from an expert review panel and been advised under what circumstances, if any, the health-care worker may continue to perform the exposure-prone procedure.

"Universal precautions" as defined by Centers for Disease Control must be adhered to by health-care workers.

Health professional associations and health facilities should develop guidelines for expert review panels and identify exposure-prone procedures.

The CDC has not identified exposure-prone procedures for HIV; neither has the American Medical Association nor any national medical specialty society. Procedures known to the CDC to have been involved in hepatitis B transmission from physician to patient are:

- Surgery: intra-abdominal, colorectal, cardiac, and other intrathoracic, open heart, cardiopulmonary bypass, and major orthopedic;

* *See "Delegates maintain stand on HIV-infected physicians,"* Texas Medicine, *January 1992, pp 30–31.*

† *See "1989 AIDS update,"* Texas Medicine, *October 1989, pp 45–47.*

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

Gynecologic and obstetric surgery: hysterectomy, vaginal, total abdominal, bilateral salpingo-oophorectomy, repair of prolapsed uterus, ovariectomy, cesarean section, forceps delivery with episiotomy, suturing (vaginal delivery), major gynecologic surgery, major and minor obstetrical surgery;

- Surgery and dentistry: oral cavity, crown work, bridge work, extraction, root canal, reduction of fractured mandible, cyst enucleation, capping tooth, pins and posts, fillings, periodontal work, denture fitting, prophylaxis, cleaning, and x-rays; and
- Nurse and technician procedures: indwelling arterial catheter maintenance and perfusion pump operation.

Procedures *suggested by the CDC* to NOT be exposure-prone are:

- physical examination (including eye, oral, rectal, vaginal);
- blood pressure checks;
- needle injection and fluid withdrawal (phlebotomy; injections [intramuscular, intradermal, subcutaneous]; needle biopsy, aspiration, lumbar puncture);
- lines and tubes (place, maintain peripheral, central intravascular line; nasogastric, endotracheal, rectal, chest tubes, urinary catheter); and
- scopics (endoscopic, laparoscopic, bronchoscopic, arthroscopic).

Prospective patients must be notified by the health-care worker who is infected by HIV or hepatitis B virus and is HBeAg positive of the worker's seropositive status and obtain the patient's consent before the patient undergoes an exposure-prone procedure unless the patient is unable to consent (ie, patient is incapacitated and an emergency exists).

10. Infected health-care workers should be given alternative opportunities for work, if practicable, and receive career counseling or job retraining.
11. Periodic retesting of HBeAg status due to resolution of infection is encouraged.
12. Infected health-care workers may perform procedures not identified as exposure-prone as long as infection control standards are adhered to.
13. Workers who fail to comply with the House Bill 7 subchapter dealing with infected workers are subject to disciplinary action by the appropriate licensing body.
14. House Bill 7 does not require the testing of health-care workers.

Reference

1. Codified in Chapter 85, Texas Health and Safety Code, TRCSA.

Legal articles in Texas Medicine *are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.*

What the Patient Self-Determination Act means for physicians

Hugh M. Barton, JD
TMA Assistant General Counsel

The federal Patient Self-Determination Act became effective December 1, 1991. This law requires hospitals and other Medicare certified institutions (such as nursing homes) to provide adult patients with written information regarding their right under state law to accept or refuse medical treatment and their right to make advance directives.

Q: Does this law create a federal "right to die?"

A: No. The law only requires that patients be given information about their rights to make advance directives under state law.

Q: What kinds of advance directives are recognized in Texas?

A: Two kinds of advance directives are recognized in Texas: a "Directive to Physicians" under the Texas Natural Death Act, and a "Durable Power of Attorney for Health Care."

Q: What responsibilities do physicians have under this new federal law?

A: Technically none, because the law is aimed at the hospital (or other health-care entity) itself. However, physicians have duties under Texas law when an advance directive has been executed. For example, in Texas, a physician who is given a Directive to Physician form under the Texas Natural Death Act must make that document a part of the patient's medical record.

Q: What should physicians expect from this new law?

A: Physicians can expect to receive more patient inquiries about refusal of life-sustaining treatment. Surveys show that the public is very fearful about medical technology, and many people do not wish to spend their final days "hooked up to machines." Physicians should be prepared to discuss these issues with patients when asked and may wish to discuss the subject with patients prior to hospitalization. Although there is no ideal time to discuss such serious issues, the time of hospital inpatient admission presents problems.

Q: Must a hospital provide advance directive forms upon request?

A: No. The act only requires that "information" concerning advance directives be provided and does not require that forms be handed to each patient. Nor does the law require a hospital to assist in executing the forms. However, many have opted to provide forms, since it is awkward to give patients information about their rights but not provide the forms with which to exercise those rights.

Q: What efforts has the Texas Medical Association made to educate physicians about this law?

A: In 1991, TMA joined forces with the Texas Hospital Association to develop materials designed to provide hospitals and physicians with the information necessary to achieve compliance with the new law. The joint effort was chosen to eliminate confusion and to allow hospitals and physicians to be unified in their approach to implementing the requirements of the new law.

Included in the materials are:

- an overview of the federal statute and the pertinent Texas laws pertaining to advance directives and informed consent;
- a listing of commonly posed questions regarding the new federal requirements and existing Texas law on advance directives and the answers to these questions;
- a sample brochure for patients containing information on advance directives, as required;
- a sample hospital policy for implementation of a patient's rights under Texas law, as required;
- an approach to educating the hospital staff and community on advance directives;
- a media reference kit on the new federal law; and
- copies of the relevant statutes included as an appendix.

The information packet was distributed to the House of Delegates, Board of Trustees, Board of Councilors, and county medical society presidents and executives. Copies of the information packet may be obtained from the TMA Office of General Counsel; the cost is $15 for members and $30 for nonmembers.

Additionally, TMA has available printed forms under the Texas Natural Death Act ("Directive to Physicians") and the Durable Power of Attorney for Health Care. Natural Death Act Directive to Physician forms are available at 15 cents each, including postage and handling, and Durable Power of Attorney for Health Care forms are available at 45 cents each, including postage and handling. Members may receive up to four forms at no charge. Forms are also available in bulk and a schedule of charges may be requested.

Send requests for information packets or forms to Office of the General Counsel, Texas Medical Association, 401 W 15th St, Austin, TX 78701.

Plain talk about referring patients for laboratory services

Hugh M. Barton, JD
TMA Assistant General Counsel

In 1989, Congress enacted the Ethics in Patient Referrals Act as part of the annual budget reconciliation process. The act's "limitation on certain physician referrals" applies, at present, only to referrals for clinical laboratory services. However, it is written in a way that suggests that other referral facilities such as imaging centers, could easily be added to it.

Physicians and clinical laboratories

The general rule of this law may be stated as follows: if a physician has a financial relationship with a clinical laboratory, then the physician may not refer a patient to the clinical laboratory for laboratory services if payment is to be made by Medicare or Medicaid, and the laboratory may not submit a Medicare or Medicaid claim for those services (1).

A "referral" by a "referring physician" includes the request by a physician for an item or service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by or to be performed by that other physician) (2). On the other hand, when a physician requests a consultation with a pathologist, the pathologist's order for clinical diagnostic laboratory tests and pathological examination services does not constitute a "referral" by a "referring physician" (3).

Financial relationships covered

A financial relationship of a physician (or immediate family member)

ith a clinical laboratory is an ownership or investment interest through equity, debt, or other means; or a "compensation arrangement" between the physician (or immediate family member) and the clinical laboratory (4).

As with most laws, Congress has provided some exceptions. There are general exceptions to both the ownership and compensation arrangement prohibitions.

The prohibitions do not apply in the following cases:

1. Physicians' services provided personally by (or under the personal supervision of) another physician in the same group practice as the referring physician (5).
2. Clinical laboratory services provided by the referring physician (or by a member of the same group practice as the referring physician, or personally by employees of such physician or group practice) in either the same building where the physician practices or in another building used by the group practice for clinical laboratory services, and billed by the physician performing or supervising the services (or by the group practice to which the physician belongs, or by a wholly owned entity of the physician or group practice) (6).

   A "group practice" is defined as two or more physicians in a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association where each member of the group provides the full range of routine services through joint use of shared office space, facilities, equipment, and personnel; all services are provided through the group and are billed in the name of the group and the amounts received are treated as group receipts; and practice overhead expenses and income are distributed in accord with previously determined methods by the group (7).
3. There is an exception for "prepaid plans," meaning generally health maintenance organizations (8).
4. There is also an exception where the referring physician has a financial relationship with a hospital unrelated to clinical laboratory services (9).
5. The Department of Health and Human Services (HHS) may specify by regulations other financial relationships that do not pose a risk of program or patient abuse (10).

Exception for ownership in publicly traded securities

The "financial relationship" in the general rule does not apply to investment securities generally available to the public in a corporation with total assets exceeding $1 million listed on a major national stock exchange (11).

Exceptions to ownership and investment prohibition

The "ownership or investment interests" also do not include clinical laboratory services provided by a hospital in Puerto Rico; laboratories in rural areas where DRG payments have been increased; and clinical laboratory services provided in a hospital where the referring physician has privileges and has an ownership or investment interest in the hospital itself and not in a subportion of the hospital (12).

Exceptions relating to compensation arrangements

There is an exception for rentals of office space where they are made under terms similar to the "safe harbor" for office space rentals.

The exceptions are a written agreement for not less than 1 year, specifying the premises to be rented and the periods of access, and compensation based on fair market value not taking into account the volume or value of referrals reimbursed under Medicare or Medicaid (13).

Also, certain employment and service arrangements with hospitals are excepted from the rule where the arrangement is for identifiable services and the amount of compensation is consistent with the fair market value and does not take into account (directly or indirectly) the volume or value of any referrals by the referring physician. Finally, the compensation must be "commercially reasonable" even if no referrals were made to the hospital (14).

Other arrangements may qualify for exception where the compensation is for specific identifiable services as a medical director or as a member of a medical advisory board; for physicians' services to a Medicare hospice patient; for physicians' services to a nonprofit blood center; or for specific identifiable administrative services under "exceptional circumstances" to be specified in regulations (15).

Physician recruitment

Money and other compensation paid by a hospital to induce a physician to relocate to the geographic area served by the hospital to be a medical staff member of the hospital is an exception to the general rule if the physician is not required to refer patients to the hospital, and if the amount of compensation does vary with the volume or value of any referrals by the referring physician (16).

Isolated transactions

An isolated financial transaction, such as a one-time sale of property, is an exception to the compensation arrangement rule if the amount of compensation is consistent with the fair market value and does not take into account (directly or indirectly) the volume or value of any referrals, and the compensation is "commercially reasonable" even if no referrals are made to the entity being sold (17).

Salaried physicians in a group practice

When a physician is employed by a group practice, his or her salary is not considered a "compensation arrangement" for purposes of the general rule (18).

Reporting requirements

All clinical laboratories billing Medicare have been sent reporting forms designed to disclose the services provided by the laboratory and the names and Unique Physician Identification Numbers of all physicians with an ownership or investment interest in the laboratory, or whose immediate relatives have an ownership or investment.

These reporting forms were to have been completed and returned no later than October 1, 1991. However, the deadline was extended to December 1, 1991.

The reporting rules do not apply where service is provided outside the United States or where it is determined that Medicare payment is made "very infrequently." Reporting also is required for parenteral and enteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, entities providing physical therapy services, and entities providing diagnostic imaging services of any type (19).

Enforcement mechanisms

HHS can enforce compliance with this law through several types of sanctions. Denial of payment is one. HHS also may require refunds for amounts billed in violation of the general rule.

A civil money penalty up to $15,000 per claim may be levied. Exclusion from Medicare and Medicaid may also be imposed.

More ominously, civil money penalties and program exclusion may be imposed for "circumvention schemes." In other words, any physician or laboratory entering into an arrangement or scheme (such as a cross-referral arrangement) with a principal purpose of assuring referrals that, if made directly, would be in violation of the law, is subject to a civil money penalty up to $100,000.

Finally, failure to report required information may bring a civil money penalty up to $10,000 for each day for which reporting was required (20).

Effective date

This law became effective with respect to clinical laboratory referrals on January 1, 1992.

Final regulations to carry out this section were to have been published by October 1, 1991, but were not.

Relationship to "safe harbor" rules

The "safe harbor" rules are just that: *rules*.

They only make certain conduct *legal* under the federal illegal remuneration *statute*, which imposes criminal sanctions. This law is a statute, which makes certain conduct *illegal* and imposes civil sanctions. A physician's relationship with a clinical laboratory must be analyzed under each statute to determine if problems exist.

For example, an investment in a clinical laboratory might technically violate the illegal remuneration statute, but be saved by compliance with an applicable safe harbor provision. Thus, there would be no risk of criminal exposure. However, that same investment might not meet the requirements of this law, and thus might pose a risk of civil sanctions. It is important to keep in mind that these laws operate completely independently of each other (21).

AMA's new position

The American Medical Association's existing "Conflicts of Interest" guidelines recognize that a physician's ownership interest in a commercial venture where there is potential for abuse is not in itself unethical.

Recently, however, at the 1991 AMA Interim Session, the Council on Ethical and Judicial Affairs submitted a report that finds the practice of self-referral presumptively inconsistent with the physician's fiduciary duty when adequate alternative facilities exist. Thus, only where physicians can demonstrate both the absence of adequate alternative facilities — a plain medical need — and the absence of alternative financing, should self-referral take place.

Specific recommendations include:

- Physicians should not refer patients to a health-care facility outside their office practices at which they do not directly provide care or services when they have an investment interest in the facility.
- Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated need in the community for the facility and alternative financing is not available. In such

cases, persons not in a position to refer patients to the facility must be given a bona fide opportunity to invest in the facility on the same terms offered to referring physicians. These terms must not be related to the past or expected volume of referrals or other business from the physicians.

- There must be no requirement that physician investors make referrals to the entity or generate business as a condition for remaining an investor.
- The return on the investment must be tied to the physician's equity in the facility rather than to the volume of referrals.
- Investment contracts should not include "noncompetition clauses" that prevent physicians from investing in other facilities.
- Physicians must disclose their investment interest to their patients when making referrals, and patients must be given a list of effective alternative facilities if any such facilities become reasonably available. The ownership interest should be disclosed to third-party payers when requested.
- Utilization review programs must be established to ensure that inappropriate or unnecessary utilization does not occur.
- Physicians with investments in referral facilities should reevaluate their activity and comply with the new AMA guidelines "to the fullest extent possible." Where compliance with the need and alternative investor criteria is not practical, reasonably available alternative facilities must be provided to the patient (22).

The Ethics in Patient Referrals Act is an important law for physicians to be aware of, even if they have no interests in clinical laboratory facilities, because the law is structured in a way that could easily be amended to include other types of health-care facilities.

In fact, the original bill introduced in 1988 had a broader scope, and the bill's sponsor, Rep Pete Stark, has stated that he would like to see the current law expanded to cover more types of health-care facilities. This makes the new AMA ethical guidelines of value to the would-be investor, as cognizance of them may eliminate the need for stricter legislation.

References

1. 42 USCA §1395nn(a)(1)(West Supp 1991).
2. Id, §1395nn(h)(7)(A).
3. Id, §1395nn(h)(7)(C).
4. Id, §1395nn(a)(2).
5. Id, §1395nn(b)(1).
6. Id, §1395nn(b)(2).
7. Id, §1395nn(h)(4).
8. Id, §1395nn(b)(3).
9. Id, §1395nn(b)(4).
10. Id, §1395nn(b)(5).
11. Id, §1395nn(c).
12. Id, §1395nn(d).
13. Id, §1395nn(e)(1).
14. Id, §1395nn(e)(2).
15. Id, §1395nn(e)(3).
16. Id, §1395nn(e)(4).
17. Id, §1395nn(e)(5).
18. Id, §1395nn(e)(6).
19. Id, §1395nn(f).
20. Id, §1395nn(g).
21. Barton, HM. The long awaited "safe-harbor" rules. Tex Med. 1991;87(10):62–64.
22. American Medical Association Council on Ethical and Judicial Affairs Report C: "Conflicts of Interest and Physician Ownership of Medical Facilities," Chicago, American Medical Association, 1991.

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Includes two appendices:

1. Coding worksheet form physicians can use to capture information necessary for assigning codes to evaluation and management services.

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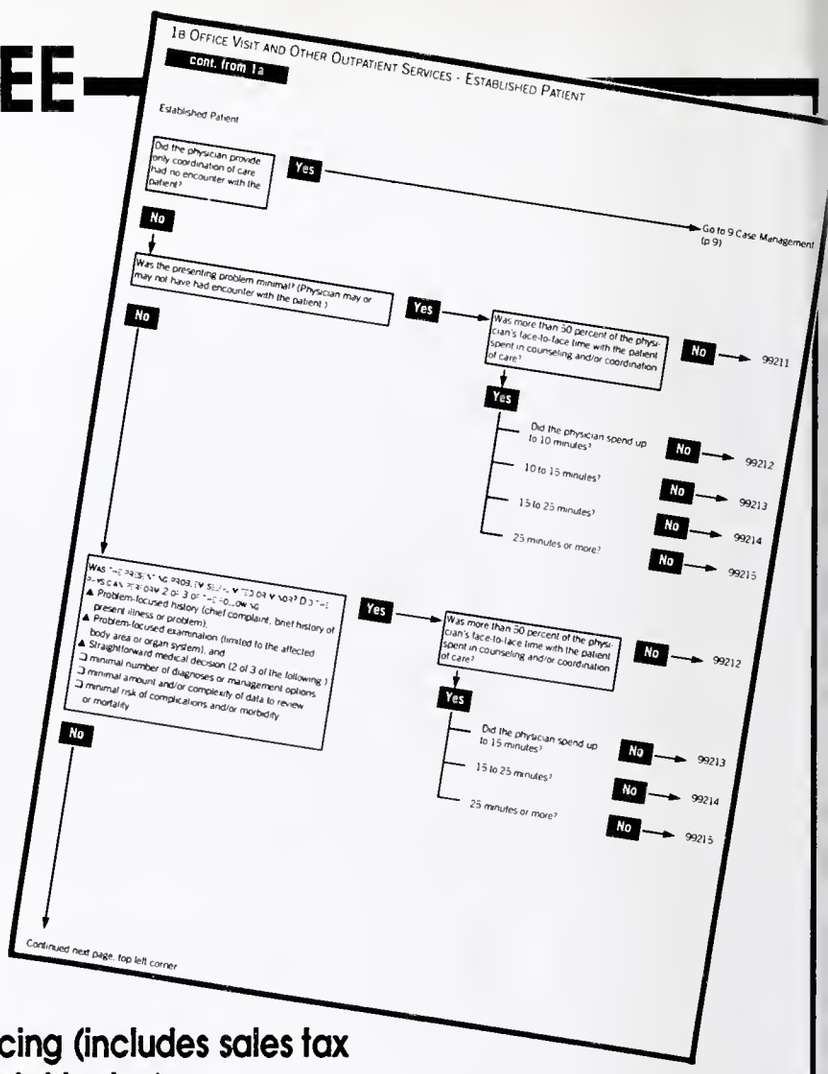

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Medical Economics

Bexar CMS wins battle with capitation plan provider

THE BEXAR COUNTY MEDICAL Society has won a round in a battle to provide better care for patients with health insurance plans that use capitation to reimburse participating physicians.

Humana Health Care, which has about 180,000 HMO enrollees in San Antonio and Corpus Christi, recently backed down from a plan to switch most of its health plan physicians to a capitated form of payment system after local physicians complained bitterly about the plan. (See box, next page.)

"The medical society recognized capitation as a potentially dangerous way for beneficiaries to receive their health-care benefits," said John Holcombe, MD, president-elect of the Bexar CMS and chairman of its Third Party Task Force.

The problem, he said, is that in a capitation system, physicians frequently do not have access to critical actuarial and demographic data regarding the population they are supposed to cover.

"This is all information that is available to an insurance company, but it's not available to a provider," said Dr Holcombe. "So we recognized that the providers were being placed in a very difficult situation in that they were agreeing to serve a population they didn't understand, for a set fee that may or may not be sufficient to cover the needs of this population."

Among several complaints lodged against the Humana capitation plan were tales of long waits for service, patients being seen only by a nurse practitioner rather than a doctor, and physicians scheduling patients on an "assembly-line" basis. One example cited by some physicians was an HMO regulation that required patients to obtain a referral from an optometrist to see an ophthalmologist.

Dr Holcombe emphasized that the medical society was not focusing on Humana, but on the technique of capitation.

"We're aware of several other programs around the state that utilize capitation," he said. "Anytime that an incentive exists to *not* provide care, then the question arises: Is this a system that provides quality health care?"

In January, Timothy Austin, a vice-president at Humana, told physicians in the Corpus Christi and San Antonio areas that several recent issues surrounding the health plan had "created disharmony in the medical staffs" at Humana's four hospitals in San Antonio. Administrators said they realized the physicians "felt that capitation for specialists' services was not the most appropriate model to utilize."

Cameron Laurence, a spokeswoman for Humana's corporate headquarters in Lexington, Ky, confirmed that there has been a recent change in the way they write HMO contracts.

"There has been a change in physician reimbursement in the HMO plan that we offer in San Antonio (and Corpus Christi)," she said. "The change is with our specialists, not ou primary care physicians. We are no capitating new contracts."

There are several ongoing inves tigations of Humana for allegedl providing substandard care unde its health plans and for alleged fals advertising.

US Rep John Dingell (D Mich), who has held hear ings on Humana before th House Energy and Com merce Committee, has re quested the Federal Trad Commission to investigat allegations from senior citi zens that Humana's Medi care HMO has engaged i false advertising.

The federal Departmen of Health and Human Ser vices inspector general's office announced in mid-De cember that it planned to au dit one of Humana's Texas hospitals as part of its ongo ing investigation of the hos pital chain's pricing policies.

And the Texas State Board of Insurance is also currently investigating sev eral complaints against Hu mana, according to an in surance board spokesman.

> "THE MEDICAL SOCIETY RECOGNIZED CAPITATION AS A POTENTIALLY DANGEROUS WAY FOR BENEFICIARIES TO RECEIVE THEIR HEALTH-CARE BENEFITS."

Dr Holcombe said the CMS' opposition to capitation is not a pocketbook issue for physicians.

"The concern that we raised was 'What happens to patients under any given reimbursement system?' We're not trying to protect the pocketbooks of physicians. That's their business," he said. "What we are interested in is the beneficiaries who frequently have no choice at all in the kind of health-care coverage they are offered. We identified capitation as a potential risk to patient care."

Donald P. Wilcox, JD, and C.J.

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

Capitation: what it means

IN A LETTER WARNING SAN ANTONIO area employers about some of the hazards of capitation, the Bexar County Medical Society spelled out what "capitation" means:

"Capitation" refers to a health-care payment system in which a physician eceives a monthly fee from an insurance carrier in return for providing care or a "block" of beneficiaries. The payment is rendered on a "per-head" ba-is, hence the term *capitation*.

For example, an allergist might be offered 11 cents per patient per month o provide all allergy services for a group of 10,000 beneficiaries. Therefore, ıe or she would receive a monthly payment of $1,100 regardless of the level of utilization of services.

Obviously, if none of the beneficiaries had allergic problems in a month, he allergist would profit. If most of the 10,000 individuals had such difficul-y, the allergist would be overwhelmed with demands for service.

rancisco, JD, of TMA's office of eneral counsel, and Mike Dabbs, MA director of quality assurance/ ıtilization, provided Bexar CMS echnical assistance and support in ormulating its plans and policies to-vards the capitation problem.

TMA's risk management workshops offer double benefit

DID YOU KNOW YOU CAN cut your risk of being sued for malpractice *and* get a reduc-ion in your medical liability insur-ance, all at the same time?

It's simple: just participate in "From Deposition to Courtroom," TMA's 1992 Risk Management workshop series, which will be pre-sented eight times in four cities this year by Jim Edwards, JD, a practic-ing malpractice defense attorney.

The workshop consists of a 3-hour seminar and 12 hours of inde-pendent study. The seminar portion workshops will focus on risk reduc-tion and patient safety and on the scope and impact of the present mal-practice litigation crisis. The work-shop will emphasize the importance of the physician-patient relationship, as well as the staff-patient relation-ship, and study guidelines for im-provements in these areas.

The independent study portion of the workshop includes viewing four videotapes titled *Defend Yourself*, which focus on the medical malprac-tice crisis and provide physicians with information on how best to avoid a lawsuit and how to respond when a suit is filed.

Workshop dates and locations are:

April 23	**Dallas**
May 21	**San Antonio**
June 11	**Houston**
August 20	**Houston**
September 19	**Austin**
October 22	**Dallas**
November 19	**San Antonio**

Physicians who successfully com-plete the seminar and independent study portions of the workshop will receive 15 hours of CME Category I credit, meeting the requirements set forth in House Bill 18. Those who, in addition to the workshop, also meet charity care requirements spelled out under the provisions of House Bill 18, will be eligible for a reduction of their medical liability insurance premium.

The cost of the 15-hour work-shop is $185 for TMA members and $285 for nonmembers. Cost for tak-ing only the 3-hour seminar is $75 for members; $125 for nonmembers. Cost for taking only the 12-hour in-dependent study course is $125 for members; $175 for nonmembers.

For more information and to reg-ister, contact the TMA risk manage-ment department at (800) 880-1300 or (512) 370-1411.

Medicare may owe you additional payments!

IF YOU WERE A HOSPITAL-salaried physician who converted to fee-for-service billing between 1982 and 1985, Medicare may owe you additional payments.

A federal class action lawsuit, *Cosgrove v Sullivan*, filed in New York has so far produced more than $40 million in additional payments to physicians. The number of claims paid so far total about 2.6 million, according to Barbara Harvey of Blue Cross and Blue Shield of Texas, the regional Medicare carrier.

However, she adds, in some areas of the country, carrier records are incomplete or unavailable, so physi-cians who think they may be eligible for such a reimbursement must iden-tify themselves and their patients.

In order to qualify for additional Medicare payments, a physician must have rendered patient services between July 1, 1984, and April 30, 1986 (for those converting to fee-for-service billing between Novem-ber 1, 1982, and October 31, 1983), or between October 1, 1985, and April 30, 1986 (for those converting between November 1, 1983, and January 31, 1985), she said.

Physicians who believe they may qualify for these additional Medicare payments should contact their Medi-care carrier, specifically identifying the *Cosgrove* case and ask for the name and telephone number of the person handling *Cosgrove* claims.

RBRVS Briefs

Time is running out to comment on RVUs

If you think your services are worth more than the government thinks they are, you need to let them know before March 24. That's the last date the Health Care Financing Administration will accept comments about and suggested changes to the relative value units in its final schedule for the resource-based relative value scale fee system.

According to HCFA administrator Gail Wilensky, PhD, some changes may be made by mid-year, but it is her "strong preference" to delay any RVU revisions until 1993 to spare carriers and her staff any extra problems. The agency will most likely announce its first set of RVU changes in the fall of 1992, for inclusion in the 1993 fee schedule.

Forward your comments to: HCFA, Dept of HHS, Attn: BPD-712-F, PO Box 26688, Baltimore, MD 21207 by March 24.

HCFA plans early Medicare claims review

With the January changeover to new evaluation and management codes for payments, each Medicare carrier has begun randomly selecting 25 claims each week for an early claims review. The process will continue through June 30, with a total of 600 claims reviewed. According to Medicare, the Early Claims Review program is intended to provide HCFA and physicians with initial information regarding the appropriate use of the new codes. HCFA will review medical records to assess whether the correct code was used to identify the service provided.

When a claim is chosen for review, the physician's office will be contacted by Medicare and requested to submit documentation to support the level of service billed on the claim. Medicare will review the documentation and determine if the visit code accurately described the service provided. If the documentation supports the code, the physician will get a letter of thanks for his/her assistance. If Medicare does not agree with the coding used, it will contact the physician and inform them of what it determined the appropriate code or codes should be. HCFA will review the following codes: Office visits — 99213, 99214, 99215, 99204, 99205; Hospital visits — 99222, 99223, 99232, 99233; Consultations — 99244, 99245, 99263, 99255; Emergency Room — 99283, 99284, 99285.

HCFA says the early claims review is intended to be purely informational and not burdensome. The result of the process will be made available to state and county medical societies later this year, HCFA said.

HCFA to require standard claim forms, UPIN numbers

HCFA has announced that after May 1, 1992, it will no longer accept "superbills" or any other nonstandard forms for payment of Medicare fees. Physicians will be required to fill out a standard HCFA-1500 form to claim both assigned and unassigned benefits. HCFA has also announced that the names and Unique Physician Identification Numbers (UPIN) are required on all referred or ordered claims for services, beginning January 1. Claims requiring, but missing, the name or UPIN of the referring or ordering physician will be subject to denial or return as incomplete claims. A HCFA spokesman warns that the implementation of the standard forms rule might be delayed if a revised version of the HCFA-1500 reflecting the new visit codes is not completed and distributed by the May 1 deadline.

TMA Speakers Bureau prepares program on RBRVS

Physicians armed with up-to-the-minute information on payment reform stand ready to respond to the torrent of inquiries TMA has received from county medical societies and hospitals looking for speakers to explain the new RBRVS Medicare payment system.

TMA has assembled a cadre of well-informed physicians who can help clear the air on payment reform. These physician speakers will share basic information on the new system, answer concerns about its implementation, and explain how the new regulations affect a physician's practice. TMA's division of medical economics, together with the public relations department, has developed a presentation on RBRVS.

"We want, as much as possible, to encourage peer-to-peer communication on major changes taking place in Medicare," said David Marcus, PhD, director of TMA's health care financing department.

Speakers from TMA's Forum on Medical Issues to talk on RBRVS or other topics may be scheduled by calling Yasemin Hadley Florey in the public relations department at (800) 880-1300 or (512) 370-1388.

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From Depression...Into the Mainstream

Please see brief summary of prescribing information on adjacent page.

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BRIEF SUMMARY

ZOLOFT™ (sertraline HCl)

INDICATIONS AND USAGE: ZOLOFT (sertraline hydrochloride) is indicated for the treatment of depression.

CONTRAINDICATIONS: None known. **WARNINGS: In patients receiving another serotonin reuptake inhibitor drug in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued that drug and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Therefore, it is recommended that ZOLOFT (sertraline hydrochloride) not be used in combination with an MAOI, or within 14 days of discontinuing treatment with an MAOI. Similarly, at least 14 days should be allowed after stopping ZOLOFT before starting an MAOI.** **PRECAUTIONS** ***General:*** **Activation of Mania/Hypomania** - During premarketing testing, hypomania or mania occurred in approximately 0.4% of ZOLOFT (sertraline hydrochloride) treated patients. Activation of mania/hypomania has also been reported in a small proportion of patients with Major Affective Disorder treated with other marketed antidepressants. **Weight Loss** - Significant weight loss may be an undesirable result of treatment with sertraline for some patients, but on average, patients in controlled trials had minimal, 1 to 2 pound weight loss, versus smaller changes on placebo. Only rarely have sertraline patients been discontinued for weight loss. **Seizure** - ZOLOFT has not been evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarket testing. Accordingly, like other antidepressants, ZOLOFT should be introduced with care in epileptic patients. **Suicide** - The possibility of a suicide attempt is inherent in depression and may persist until significant remission occurs. Close supervision of high risk patients should accompany initial drug therapy. Prescriptions for ZOLOFT should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. **Weak Uricosuric Effect** - ZOLOFT is associated with a mean decrease in serum uric acid of approximately 7%. The clinical significance of this weak uricosuric effect is unknown, and there have been no reports of acute renal failure with ZOLOFT. **Use in Patients with Concomitant Illness** - Clinical experience with ZOLOFT in patients with certain concomitant systemic illness is limited. Caution is advisable in using ZOLOFT in patients with diseases or conditions that could affect metabolism or hemodynamic responses. ZOLOFT has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from clinical studies during the product's premarket testing. However, the electrocardiograms of 774 patients who received ZOLOFT in double-blind trials were evaluated and the data indicate that ZOLOFT is not associated with the development of significant ECG abnormalities. ZOLOFT is extensively metabolized by the liver. The pharmacokinetics of ZOLOFT have not been studied in patients with significant hepatic dysfunction nor have patients with significant hepatic dysfunction been evaluated during treatment with ZOLOFT. Accordingly, ZOLOFT should be used with caution in such patients. Since ZOLOFT is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. However, until the pharmacokinetics of ZOLOFT have been studied in patients with renal impairment and until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with ZOLOFT, it should be used with caution in such patients. **Interference with Cognitive and Motor Performance** - In controlled studies, ZOLOFT did not cause sedation and did not interfere with psychomotor performance. ***Information for Patients:*** Physicians are advised to discuss the following issues with patients for whom they prescribe ZOLOFT: Patients should be told that although ZOLOFT has not been shown to impair the ability of normal subjects to perform tasks requiring complex motor and mental skills in laboratory experiments, drugs that act upon the central nervous system may affect some individuals adversely. Patients should be told that although ZOLOFT has not been shown in experiments with normal subjects to increase the mental and motor skill impairments caused by alcohol, the concomitant use of ZOLOFT and alcohol in depressed patients is not advised. Patients should be told that while no adverse interaction of ZOLOFT with over-the-counter (OTC) drug products is known to occur, the potential for interaction exists. Thus, the use of any OTC product should be initiated cautiously according to the directions of use given for the OTC product. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. Patients should be advised to notify their physician if they are breast-feeding an infant. ***Laboratory Tests:*** None. ***Drug Interactions:*** **Potential Effects of Coadministration of Drugs Highly Bound to Plasma Proteins** - Because sertraline is tightly bound to plasma protein, the administration of ZOLOFT (sertraline hydrochloride) to a patient taking another drug which is tightly bound to protein (e.g., warfarin, digitoxin) may cause a shift in plasma concentrations potentially resulting in an adverse effect. Conversely, adverse effects may result from displacement of protein-bound ZOLOFT by other tightly bound drugs. In a study comparing prothrombin time AUC (0-120 hr) following dosing with warfarin (0.75 mg/kg) before and after 21 days of dosing with either ZOLOFT (50-200 mg/day) or placebo, there was a mean increase in prothrombin time of 8% relative to baseline for ZOLOFT compared to a 1% decrease for placebo ($p<0.02$). The normalization of prothrombin time for the ZOLOFT group was delayed compared to the placebo group. The clinical significance of this change is unknown. Accordingly, prothrombin time should be carefully monitored when ZOLOFT therapy is initiated or stopped. **CNS Active Drugs** - In a study comparing the disposition of intravenously administered diazepam before and after 21 days of dosing with either ZOLOFT (50 to 200 mg/day escalating dose) or placebo, there was a 32% decrease relative to baseline in diazepam clearance for the ZOLOFT group compared to a 19% decrease relative to baseline for the placebo group ($p<0.03$). There was a 23% increase in T_{max} for desmethyldiazepam in the ZOLOFT group compared to a 20% decrease in the placebo group ($p<0.03$). The clinical significance of these changes is unknown. In a placebo-controlled trial in normal volunteers, the administration of two doses of ZOLOFT did not significantly alter steady-state lithium levels or the renal clearance of lithium. Nonetheless, at this time, it is recommended that plasma lithium levels be monitored following initiation of ZOLOFT therapy with appropriate adjustments to the lithium dose. The risk of using ZOLOFT in combination with other CNS active drugs has not been systematically evaluated. Consequently, caution is advised if the concomitant administration of ZOLOFT and such drugs is required. **Hypoglycemic Drugs** - In a placebo-controlled trial in normal volunteers, administration of ZOLOFT for 22 days (including 200 mg/day for the final 13 days) caused a statistically significant 16% decrease from baseline in the clearance of tolbutamide following an intravenous 1000 mg dose. ZOLOFT administration did not noticeably change either the plasma protein binding or the apparent volume of distribution of tolbutamide, suggesting that the decreased clearance was due to a change in the metabolism of the drug. The clinical significance of this decrease in tolbutamide clearance is unknown. **Atenolol** - ZOLOFT (100 mg) when administered to 10 healthy male subjects had no effect on the beta-adrenergic blocking ability of atenolol. **Microsomal Enzyme Induction** - Preclinical studies have shown ZOLOFT to induce hepatic microsomal enzymes. In clinical studies ZOLOFT was shown to induce hepatic enzymes minimally as determined by a small (5%) but statistically significant decrease in antipyrine half-life following administration of 200 mg/day for 21 days. This small change in antipyrine half-life reflects a clinically insignificant change in hepatic metabolism. **Electroconvulsive Therapy** - There are no clinical studies establishing the risks or benefits of the combined use of electroconvulsive therapy (ECT) and ZOLOFT. **Alcohol** - Although ZOLOFT did not potentiate the cognitive and psychomotor effects of alcohol in experiments with normal subjects, the concomitant use of ZOLOFT and alcohol in depressed patients is not recommended. ***Carcinogenesis, Mutagenesis, Impairment of Fertility:*** Lifetime carcinogenicity studies were carried out in CD-1 mice and Long-Evans rats at doses up to 40 mg/kg in mice (10 times on a mg/kg basis and the same on a mg/m^2 basis as the maximum recommended human dose) and at doses up to 40 mg/kg in rats (10 times on a mg/kg basis and 2 times on a mg/m^2 basis, the maximum recommended human dose). There was a dose-related increase in the incidence of liver adenomas in male mice receiving sertraline at 10-40 mg/kg. No increase was seen in female mice or in rats of either sex receiving the same treatments, nor was there an increase in hepatocellular carcinomas. Liver adenomas have a variable rate of spontaneous occurrence in the CD-1 mouse and are of unknown significance to humans. There was an increase in follicular adenomas of the thyroid in female rats receiving sertraline at 40 mg/kg; this was not accompanied by thyroid hyperplasia. While there was an increase in uterine adenocarcinomas in rats receiving sertraline at 10-40 mg/kg compared to placebo controls, this effect was not clearly drug related. Sertraline had no genotoxic effects, with or without metabolic activation, based on the following assays: bacterial mutation assay; mouse lymphoma mutation assay; and tests for cytogenetic aberrations *in vivo* in mouse bone marrow and *in vitro* in human lymphocytes. A decrease in fertility was seen in one of two rat studies at a dose of 80 mg/kg (20 times the maximum human dose on a mg/kg basis and 4 times on a mg/m^2 basis). ***Pregnancy—Pregnancy Category B:*** **Teratogenic Effects** - Reproduction studies have been performed in rats and rabbits at doses up to approximately 20 times and 10 times the maximum daily human mg/kg dose (4 to 4.5 times the mg/m^2 dose), respectively. There was no evidence of teratogenicity at any dose level. At doses approximately 2.5-10 times the maximum daily human mg/kg dose, sertraline was associated with delayed assification in fetuses, probably secondary to effects on the dams. There are no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed. **Non-teratogenic Effects** - There was also decreased neonatal survival following maternal administration of sertraline at doses as low as approximately 5 times the maximum human mg/kg dose. The decrease in pup survival was shown to be most probably due to *in utero* exposure to sertraline. The clinical significance of these effects is unknown. **Labor and Delivery** - The effect of ZOLOFT on labor and delivery in humans is unknown. **Nursing Mothers** - It is not known whether, and if so in what amount, sertraline or its metabolites are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when ZOLOFT is administered to a nursing woman. **Pediatric Use** - Safety and effectiveness in children have not been established. **Geriatric Use** - Several hundred elderly patients have participated in clinical studies with ZOLOFT. The pattern of adverse reactions in the elderly was similar to that in younger patients. **ADVERSE REACTIONS** ***Commonly Observed:*** The most commonly observed adverse events associated with the use of ZOLOFT (sertraline hydrochloride) and not seen at an equivalent incidence among placebo-treated patients were: gastrointestinal complaints, including nausea, diarrhea/loose stools and dyspepsia; tremor; dizziness; insomnia; somnolence; increased sweating; dry mouth; and male sexual dysfunction (primarily ejaculatory delay). ***Associated with Discontinuation of Treatment:*** Fifteen percent of 2710 subjects who received ZOLOFT in premarketing multiple dose clinical trials discontinued treatment due to an adverse event. The more common events (reported by at least 1% of subjects) associated with discontinuation included agitation, insomnia, male sexual dysfunction (primarily ejaculatory delay), somnolence, dizziness, headache, tremor, anorexia, diarrhea/loose stools, nausea, and fatigue. ***Incidence in Controlled Clinical Trials:*** The table that follows enumerates adverse events that occurred at a frequency of 1% or more among ZOLOFT patients who participated in controlled trials comparing titrated ZOLOFT with placebo. Most patients received doses of 50 to 200 mg per day.

Treatment-Emergent Adverse Experience Incidence in Placebo-Controlled Clinical Trials*

Adverse Experience	ZOLOFT (N=861) (Percent of Patients Reporting)	Placebo (N=853) (Percent of Patients Reporting)
Autonomic Nervous System Disorders		
Mouth Dry	16.3	9.3
Sweating Increased	8.4	2.9
Cardiovascular		
Palpitations	3.5	1.6
Chest Pain	1.0	1.6
Central and Peripheral Nervous System Disorders		
Headache	20.3	19.0
Dizziness	11.7	6.7
Tremor	10.7	2.7
Paresthesia	2.0	1.8
Hypoesthesia	1.7	0.6
Twitching	1.4	0.1
Hypertonia	1.3	0.4
Disorders of Skin and Appendages		
Rash	2.1	1.5
Gastrointestinal Disorders		
Nausea	26.1	11.8
Diarrhea/Loose Stools	17.7	9.3
Constipation	8.4	6.3
Dyspepsia	6.0	2.8
Vomiting	3.8	1.8
Flatulence	3.3	2.5
Anorexia	2.8	1.6
Abdominal Pain	2.4	2.2
Appetite Increased	1.3	0.9
General		
Fatigue	10.6	8.1
Hot Flushes	2.2	0.5
Fever	1.6	0.6
Back Pain	1.5	0.9
Metabolic and Nutritional Disorders		
Thirst	1.4	0.9
Musculoskeletal System Disorders		
Myalgia	1.7	1.5
Psychiatric Disorders		
Insomnia	16.4	8.8
Sexual Dysfunction-Male (1)	15.5	2.2
Somnolence	13.4	5.9
Agitation	5.6	4.0
Nervousness	3.4	1.9
Anxiety	2.6	1.3
Yawning	1.9	0.2
Sexual Dysfunction-Female (2)	1.7	0.2
Concentration Impaired	1.3	0.5
Reproductive		
Menstrual Disorder (2)	1.0	0.5
Respiratory System Disorders		
Rhinitis	2.0	1.5
Pharyngitis	1.2	0.9
Special Senses		
Vision Abnormal	4.2	2.1
Tinnitus	1.4	1.1
Taste Perversion	1.2	0.7
Urinary System Disorders		
Micturition Frequency	2.0	1.2
Micturition Disorder	1.4	0.5

*Events reported by at least 1% of patients treated with ZOLOFT are included.
(1) - % based on male patients only: 271 ZOLOFT (primarily ejaculatory delay) and 271 placebo patients.
(2) - % based on female patients only: 590 ZOLOFT and 582 placebo patients.

Other Events Observed During the Premarketing Evaluation of ZOLOFT (sertraline hydrochloride): During its premarketing assessment, multiple doses of ZOLOFT were administered to approximately 2700 subjects. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients (only those not already listed in the tabulated results from placebo-controlled trials appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. Events of major clinical importance are also described in the PRECAUTIONS section. **Autonomic Nervous System Disorders**—*Infrequent:* flushing, mydriasis, increased saliva, cold clammy skin; *Rare:* pallor. **Cardiovascular**—*Infrequent:* postural dizziness, hypertension, hypotension, postural hypotension, edema, dependent edema, periorbital edema, peripheral edema, peripheral ischemia, syncope, tachycardia; *Rare:* precardial chest pain, substernal chest pain, aggravated hypertension, myocardial infarction, varicose veins. **Central and Peripheral Nervous System Disorders**—*Frequent:* confusion; *Infrequent:* ataxia, abnormal coordination, abnormal gait, hyperesthesia, hyperkinesia, hypokinesia, migraine, nystagmus, vertigo; *Rare:* local anesthesia, coma, convulsions, dyskinesia, dysphania, hyporeflexia, hypotonia, ptosis. **Disorders of Skin and Appendages**—*Infrequent:* acne, alopecia, pruritus, erythematous rash, maculopapular rash, dry skin; *Rare:* bullous eruption, dermatitis, erythema multiforme, abnormal hair texture, hypertrichosis, photosensitivity reaction, follicular rash, skin discoloration, abnormal skin odor, urticaria. **Endocrine Disorders**—*Rare:* exophthalmos, gynecomastia. **Gastrointestinal Disorders**—*Infrequent:* dysphagia, eructation; *Rare:* diverticulitis, fecal incontinence, gastritis, gastroenteritis, glossitis, gum hyperplasia, hemorrhoids, hiccup, melena, hemorrhagic peptic ulcer, proctitis, stomatitis, ulcerative stomatitis, tenesmus, tongue edema, tongue ulceration. **General**—*Frequent:* asthenia; *Infrequent:* malaise, generalized edema, rigors, weight decrease, weight increase; *Rare:* enlarged abdomen, halitosis, otitis media, ophthous stomatitis. **Hematopoietic and Lymphatic**—*Infrequent:* lymphadenopathy, purpura; *Rare:* anemia, anterior chamber eye hemorrhage. **Metabolic and Nutritional Disorders**—*Rare:* dehydration, hypercholesteralemia, hypoglycemia. **Musculoskeletal System Disorders**—*Infrequent:* arthralgia, arthrasis, dystonia, muscle cramps, muscle weakness; *Rare:* hernia. **Psychiatric Disorders**—*Infrequent:* abnormal dreams, aggressive reaction, amnesia, apathy, delusion, depersonalization, depression, aggravated depression, emotional lability, euphoria, hallucination, neurosis, paranoid reaction, suicide ideation and attempt, teeth-grinding, abnormal thinking; *Rare:* hysteria, somnambulism, withdrawal syndrome. **Reproductive**—*Infrequent:* dysmenorrhea (2), intermenstrual bleeding (2); *Rare:* amenorrhea (2), balanoposthitis (1), breast enlargement (2), female breast pain (2), leukorrhea (2), menorrhagia (2), atrophic vaginitis (2).

(1) - % based on male subjects only: 1005; (2) - % based on female subjects only: 1705.

Respiratory System Disorders—*Infrequent:* bronchospasm, coughing, dyspnea, epistaxis; *Rare:* bradypnea, hyperventilation, sinusitis, stridor. **Special Senses**—*Infrequent:* abnormal accommodation, conjunctivitis, diplopia, earache, eye pain, xerophthalmia; *Rare:* abnormal lacrimation, photophobia, visual field defect. **Urinary System Disorders**—*Infrequent:* dysuria, face edema, nocturia, polyuria, urinary incontinence; *Rare:* oliguria, renal pain, urinary retention. **Laboratory Tests:** In man, asymptomatic elevations in serum transaminases (SGOT [or AST] and SGPT [or ALT]) have been reported infrequently (approximately 0.8%) in association with ZOLOFT administration. These hepatic enzyme elevations usually occurred within the first 1 to 9 weeks of drug treatment and promptly diminished upon drug discontinuation. ZOLOFT therapy was associated with small mean increases in total cholesterol (approximately 3%) and triglycerides (approximately 5%), and a small mean decrease in serum uric acid (approximately 7%) of no apparent clinical importance. **DRUG ABUSE AND DEPENDENCE** ***Controlled Substance Class*** - ZOLOFT (sertraline hydrochloride) is not a controlled substance. ***Physical and Psychological Dependence*** - ZOLOFT has not been systematically studied, in animals or humans, for its potential for abuse, tolerance, or physical dependence. However, the premarketing clinical experience with ZOLOFT did not reveal any tendency for a withdrawal syndrome or any drug-seeking behavior. As with any new CNS active drug, physicians should carefully evaluate patients for history of drug abuse and follow such patients closely, observing them for signs of ZOLOFT misuse or abuse (e.g., development of tolerance, incrementation of dose, drug-seeking behavior). **OVERDOSAGE** ***Human Experience*** - There have been 3 cases of ZOLOFT (sertraline hydrochloride) overdosage (approximately 750-2,100 mg). No specific therapy was required for any of the 3 patients, all of whom recovered completely. ***Management of Overdoses*** - Establish and maintain an airway, insure adequate oxygenation and ventilation. Activated charcoal, which may be used with sorbitol, may be as or more effective than emesis or lavage, and should be considered in treating overdose. Cardiac and vital signs monitoring is recommended along with general symptomatic and supportive measures. There are no specific antidotes for ZOLOFT. Due to the large volume of distribution of ZOLOFT, forced diuresis, dialysis, hemoperfusion, and exchange transfusion are unlikely to be of benefit. In managing overdosage, consider the possibility of multiple drug involvement. The physician should consider contacting a poison control center on the treatment of any overdose.

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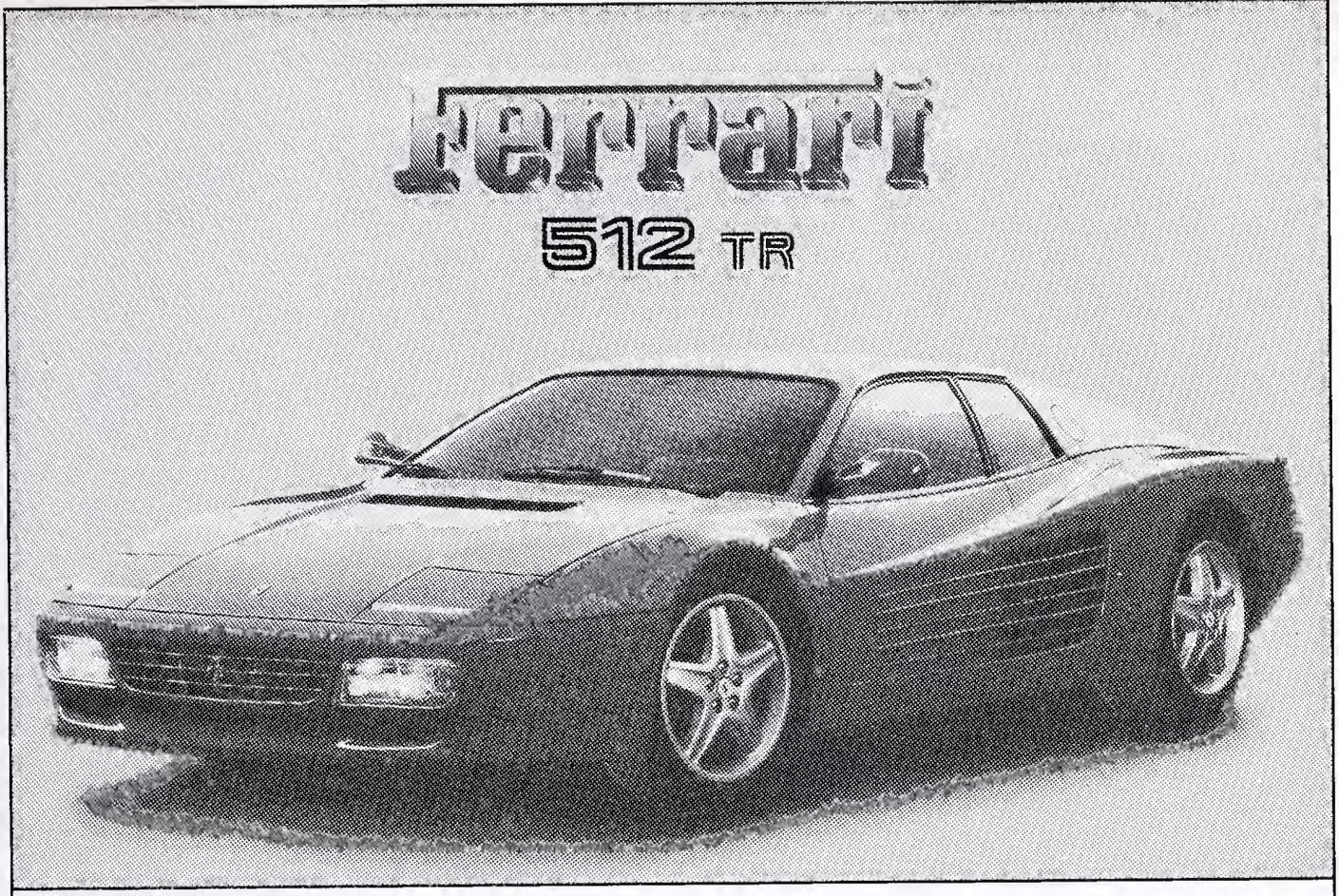

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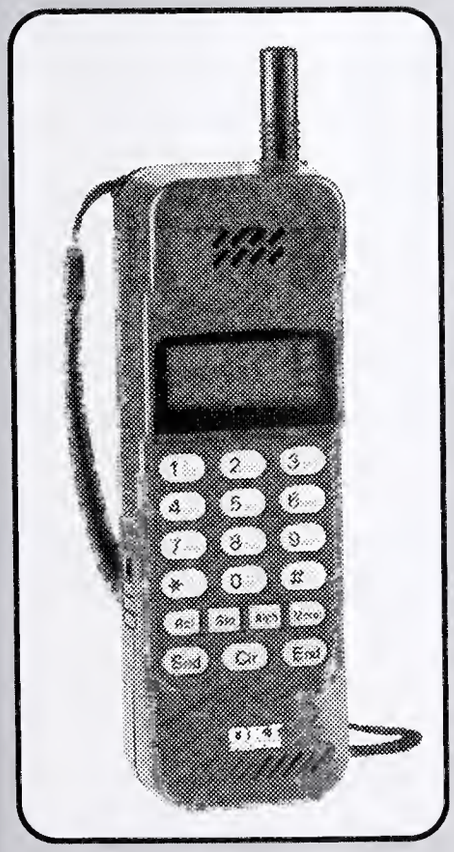

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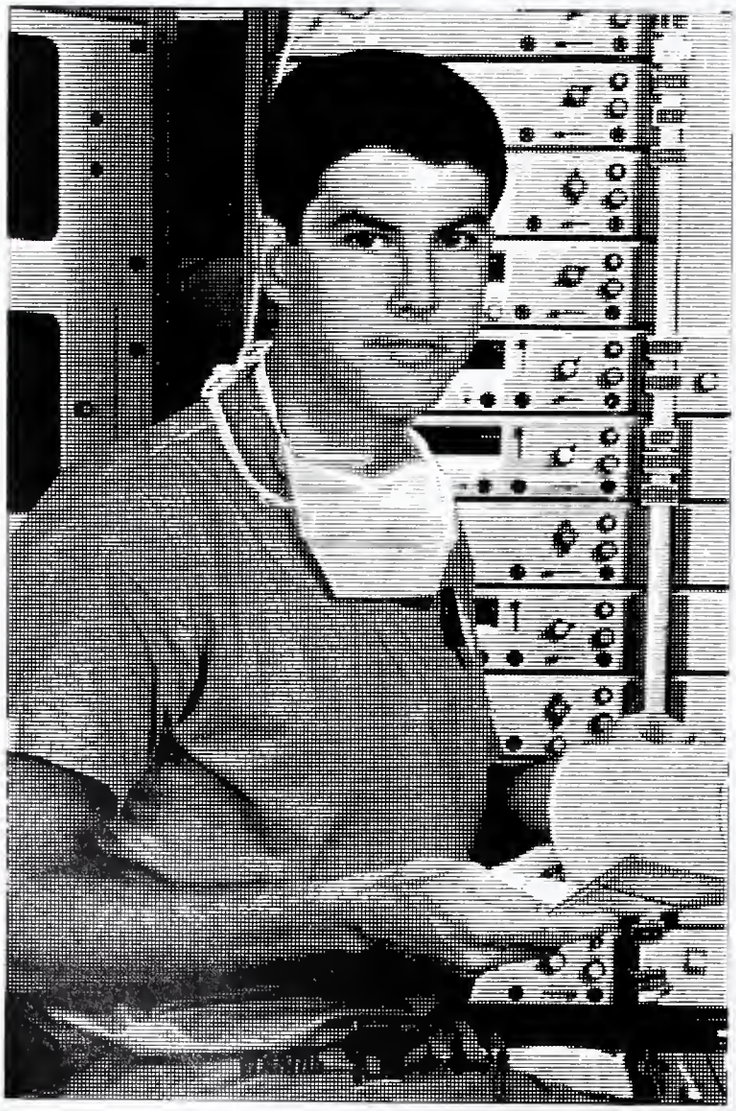

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

Adolescent mental health: a review of preventive interventions

Craig Bushong, MD
John Coverdale, MD
John Battaglia, MD

Over the past 30 years, adolescents represent the only age group in the United States whose health status has not improved significantly. In this population, major health problems that are becoming increasingly important in regard to preventive intervention include substance abuse, depression, teenage pregnancy, and AIDS. Research in adolescent mental health during the past decade has focused on both the etiology and the prevention of problem behaviors. We review the development and application of various preventive intervention approaches in the field of adolescent mental health and discuss implications for future directions.

Drs Bushong and Coverdale, Department of Psychiatry, Baylor College of Medicine, Houston. Dr Battaglia, Department of Psychiatry, The University of Texas Southwestern Medical Center, Dallas. Send reprint requests to Dr Bushong, 4550 Post Oak Place #320, Houston, TX 77027.

Over the past 30 years, adolescents constitute the only population in the United States whose health status has not improved (1). Increasingly, adolescent life-style and risk-taking behaviors are influencing the major morbidities of youth, which include substance abuse, depression, teenage pregnancy, and other major health problems. Causes of mortality have also changed dramatically in the past 3 decades. Violent death has replaced communicable disease as the primary cause of juvenile mortality, with more than 75% of adolescent deaths now caused by accidents, suicide, and homicide (1,2).

The emphasis in adolescent mental health research over the past decade has focused on two general areas of study (3). The first, etiological research, includes a substantial literature and attempts to identify factors that may be important determinants of future "problem behaviors" such as substance use, teenage pregnancy, delinquency, and psychiatric disturbance. In addition to epidemiological data, theories on stages of adolescent development, behavioral and environmental change, and social learning have gained importance in creating a multidimensional developmental context in which to study adolescent behavior (4).

The second area of research, preventive intervention, focuses on the development and testing of intervention strategies to prevent the onset of problem behaviors. We review here the development and application of various approaches to preventive intervention in the field of adolescent mental health and discuss implications for future directions.

ADOLESCENT MENTAL HEALTH PROBLEMS AND CONCERNS

The literature on adolescent development emphasizes intrapsychic and interpersonal developmental tasks, including the consolidation of identity formation, emancipation from parents and families, and developing a sense of competence and a capacity for intimacy (5). In 1958, Anna Freud wrote that the turmoil of adolescence was "no more than the external indication that . . . internal adjustments are in progress" (6). The new adolescent culture, however, has superimposed external tasks of development that were not present 30 years ago. In an era of increasing social and economic opportunity, many concerns about adolescent mental health are becoming the focus of increasing investigation. It seems paradoxical that during an era that heralds unprecedented prosperity, millions of adolescents continue to use psychoactive drugs to alter their feelings and escape their environment (5). Recent findings regarding substance use include the following:

- More than 30% of sixth graders report getting drunk in the past year (7).
- Two thirds of American youth experiment with an illicit drug before finishing high school (8).
- Among high school seniors, 5% drink daily and almost 40% have had five or more drinks in a row at least once in the past 2 weeks (9).
- Among seniors, 5% smoke marijuana daily and 40% have tried some illicit drug other than marijuana; about 7% have used cocaine at least once in the past month (10).
- The incidence of physical abuse and neglect is increased in the offspring of teenage parents who abuse alcohol and drugs (11).

Other adolescent health and mental health problems are receiving greater attention and study. A recent report estimates that as many as 15% of high school students suffer from clinical depression syndromes (12). This percentage does not include those adolescents with depressive disorders that might be associated with delinquency, substance abuse, sexual acting out, or other problem behaviors (13). Regarding teenage pregnancy, approximately 700,000 unmarried females aged 19 years or younger in the United States become pregnant each year; 85% of these pregnancies are unintended (14). In addition, the frequency of suicide attempts and completions has increased significantly; in the past 25 years, suicides by 15- to 24-year-old women and men has increased twofold and threefold, respectively (15). There were about 5,000 completed suicides in 1989, and the number of deaths by suicide is second only to accidental deaths among older adolescents (16).

While many professionals may be surprised to learn that psychiatric and behavioral problems have replaced infectious disease as the major cause of morbidity and mortality of adolescents in the United States, adolescents are apparently less surprised. When teenagers are asked about their own health needs and concerns, what emerges is their primary concern in the areas of psychological and social adjustment (17). Several studies find that psychological and social problems account for most adolescent health concerns (18–20). Depression, nervousness, and stress are recurrent themes that accompany other typical adolescent health concerns such as weight and dental problems, acne, and sexually transmitted disease (20).

Although adolescents are willing to acknowledge their health and personal concerns, they are less likely to seek help for these concerns. Instead, they tend to avoid health-care providers for help with psychological issues (21). Fear that confidentiality might not be maintained, or the perception that health-care professionals are unable to help with mental health problems, may partially explain adolescents' reluctance to seek help for emotional issues (21). Evidence shows that professionals underestimate the level of responsibility that most students feel for their health. Levenson et al found that adolescents attributed more importance to their health than physicians, school nurses, or teachers predicted (22). While risk-taking behaviors may be a normal part of adolescent development, so too is the sense of responsibility for personal health that most teenagers assume.

PREVENTION INTERVENTION RESEARCH

While numerous preventive programs are being developed and implemented around the nation to educate the public on important mental health concerns, until recently research on the impact of many educational programs and preventive efforts has been relatively sparse.

Until the past decade, traditional preventive programs often relied on intuitive notions regarding causation and prevention of problem behaviors. Standard preventive programs in the past used primarily approaches based on knowledge or on interpersonal education. Knowledge-based programs are developed on the implicit assumption that the way to change adolescents' attitudes and behavior is by increasing their factual knowledge (23). Interpersonal education or "affective" approaches focus on strategies to "enhance self-esteem and responsible decision-making as well as to enrich the personal and social development of students" (24). A review of the literature, however, presents interesting findings: no clear-cut relationship exists between attitudes and knowledge and subsequent behavior (25). Indeed, several studies have clearly shown these approaches are ineffective in changing behavior (26–28).

ALCOHOL AND DRUG PREVENTION

Alcohol and drug abuse is the area of preventive education that receives the most funding. The National Institute on Alcohol Abuse and Alcoholism reviewed traditional approaches to alcohol and drug prevention in 1986 and concluded the following:

> ". . . Results . . . have been mixed and there is considerable continuing debate about their effectiveness. Each has been shown to change knowledge and attitudes to some degree, (but) none has been shown to change behavior positively and consistently and in fact, some of the educational approaches seem to have stimulated use of alcohol and other drugs" (7).

One popular preventive program that has spent millions of dollars over the past several years without systematic investigation of effectiveness is the well-publicized "Just Say No" campaign for drug prevention. Data suggest that programs that use a variety of "scare tactics" are often unsuccessful in influencing behavior (29). This type of approach by social

influence may not be highly effective because, as research shows, while most students have sufficient skills to "say no," they lack sufficient motivation to do so (30). However, exaggerated claims about harmful drug effects are being replaced increasingly by more balanced reports describing more readily observable consequences such as poor school performance, decreased interest in extracurricular activities, and impaired interpersonal relationships (31).

SUICIDE PREVENTION

A 1988 national survey of school-based programs to prevent adolescent suicide indicated that these programs "adopt a 'universal' strategy, ie, they are directed to all teenagers regardless of individual susceptibilities, experience, or vulnerability status" (32). The impact of these programs appears limited by their focus on the general adolescent population (their combined outreach is less than 1% of the population aged 15 to 19 years) and there is no systematic research to show "that the programs are either effective, safe or necessary" (32). A recent study suggests in fact, that programs for suicide prevention may produce some unwanted effects. Previous suicide attempters, for example, were significantly more likely than nonattempters to indicate that talking about suicide in the classroom "makes some kids more likely to try to kill themselves" (33).

SEX EDUCATION

An extensive review of school-based programs for sex education found that they had little or no effects on sexual activity, contraception, or teenage pregnancy (34). Although the studies reviewed had significant limitations, the risk of "widespread implementation of a health education concept based on preconceived expectations, prior to adequate evaluation" was emphasized as an important consideration in preventive strategies (34).

In a 1988 study involving seventh-grade and tenth-grade students in Providence, RI, correlations between knowledge about AIDS and behavioral attitudes were minimal (35). For example, although 91% of students knew they could not get AIDS by touching someone, 55% indicated they would not "take a chance by touching someone with AIDS" (35). Another example of this inconsistency in sex education concerns contraception. An increase in contraceptive knowledge, coupled with a positive change in attitude toward contraceptive use, does not necessarily yield significant changes in contraceptive behavior (36,37). Sexuality courses have been found to increase students' tolerance toward the sexual practices of others, but these courses have no consistent effect on students' own sexual and personal value systems (38).

In summary, most preventive research suggests that approaches through knowledge dissemination and interpersonal education do not consistently and significantly correlate with subsequent attitudes and behavior. Therefore, we are not surprised that those programs oriented toward increasing knowledge or interpersonal education have been, at best, minimally successful in reducing problematic behavior.

EFFECTIVE PREVENTION-CENTERED APPROACHES

In recent years, research on prevention has emphasized the development of training in behavioral skills that focuses on psychosocial factors contributing to problem behaviors. Jessor originally introduced a model that conceptualizes problem behavior such as substance abuse as a socially learned, functional, and purposive behavior resulting from the interaction of social and personal factors (39). A developmental progression of substance use (from tobacco to alcohol to marijuana and other substances) has been described that, based on common underlying determinants, links substance abuse to other problem behaviors such as premature sexual activity and delinquency (40–42). Programs for behavioral skills using approaches either through social influence or through training in personal and social skills have received the most recent attention in targeting the many factors underlying various forms of problem behaviors.

Approaches through social influence, developed primarily from the work of Evans and colleagues (43), are based on the assumption that students can be "inoculated" against social influences to engage in problem behavior. This approach involves not only making students aware of premorbid social influences but teaching them specific strategies (such as refusal skills) to resist those influences (24,44). While most current funding for research in prevention is given for this approach, and while the original model has been expanded to include the use of peer leaders together with role playing and social reinforcement techniques (24), this approach has proven effective primarily in delaying the onset of cigarette smoking in junior high school students (the primary target of these approaches). Thus far, the approach through social influence seems to have limited efficacy in significantly reducing substance abuse (30), and we have little data on the

impact of this approach on other areas of problem behavior.

Approaches through training in personal and social skills combine social competence and cognitive skills development and teach adolescents skills both for specific problems and for general life. One model curriculum for prevention, developed by Botvin et al and entitled "Life Skills Training," includes components that teach short- and long-term consequences of drug use, assertiveness and peer resistance techniques, decision-making strategies that promote independent thinking, anxiety management, and skills for increasing self-esteem and self-control (43). A modification of this curriculum developed by Forman and Linney includes a manual for parents and a checklist for identifying high-risk behavior (45).

Research indicates that these approaches through training in behavioral skills can reduce substance abuse (29,43) and reduce the occurrence of unintended pregnancies among unmarried adolescents (14). Recent approaches to prevention minimize reliance on disseminating knowledge and place more emphasis on developing decision-making skills, training in assertiveness, and heightening self-esteem (46). Instead of arousing fear by using intimidating and frightening facts regarding long-term health outcomes, these programs tend to highlight immediate social and physiological consequences of problem behavior while seeking to improve short-term social skills.

Many of these programs employ peer leaders who are trained to teach and model social and behavioral skills that enable students to, for example, identify and resist the various pressures to use tobacco presented by peers, parents, and the advertising media (46). Peer group approaches may also be effective, particularly by addressing adolescent grandiose egocentrism; ie, the belief in immunity from negative consequences resulting from one's own behavior (47). Preventive intervention programs are also being designed to help adolescents understand the functional meanings of problem behaviors — eg, seeing drug use as a coping mechanism for dealing with boredom, or as a strategy to reduce stress, or as a way of gaining admission to a peer group by signalling acceptance of a common unconventional behavior (46).

A useful theoretical model of health education, the PRECEDE planning model, includes three categories of factors that can influence whether individuals adopt and practice useful health behaviors (48). The first category, *predisposing factors*, includes knowledge, beliefs, attitudes, and some demographic variables. The second category, *enabling factors*, includes the accessibility of health resources and the community's commitment to health. The third category, *reinforcing factors*, includes effects of family, peers, teachers, and health providers. A program of intervention may have the best probability of influencing behavior if factors in all three categories are considered and addressed.

IMPLICATIONS FOR FUTURE INTERVENTIONS AND RESEARCH

As research improves in identifying the important components of programs considered to be effective, future interventions may benefit from the following recommendations:

First, schools can play an important role in promoting positive attitudes toward mental health. Across the country, schools are becoming increasingly involved in issues and activities that were once handled by the family. The historical development of society's tendency to make school personnel assume family functions and solve social problems that nobody else has been able to solve has been well described (49, 50). To date, the most effective approaches to school-based prevention appear to be the previously described training in behavioral skills (14,44,45) and the more recent comprehensive change in the school climate (51). This latter approach involves coordinating various projects designed to improve school climate as a way of reducing problem behaviors, and results thus far are extremely encouraging. This unique approach comprises faculty retreats, courses in life skills, school pride days, teen talk lines, and after-school activities (29).

These school-based approaches appear to be most effective when initiated in early adolescent years, particularly the years marking transition to middle or junior high school (52). Programs may have the best chance of significant and sustained effects if they are intensive and extend beyond a traditional brief (ie, 1 to 8 weeks) interval. Also important to consider in designing programs for intervention are demographic variables such as age, gender, culture, and ethnic background. Furthermore, the effectiveness of school-based programs depends on consistent involvement and support of other social and government institutions. The future of these programs is promising only in the context of consistent government policy that includes funding for curriculum development, implementation, evaluation, and maintenance (50).

Second, coordination of preventive efforts between school, community agencies and resources, and the media appears to be an effective model for intervention (24,52,53). The School/Community Program for Sexual Risk Reduction Among Teens (14) is one example of a comprehensive school/community intervention. This program targeted children enrolled in the public school system and included parents, teachers, community leaders, and church representatives. Evaluation of the program's results indicated a dramatic decrease in the rate of adolescent pregnancy. In addition, honest, objective, and credible presenters of the program are better received by adolescents than those who are distant, aloof, or appear rushed (54). We have also questioned whether the participation of young professionals who serve as role models may also facilitate successful outcomes (55).

Third, environmental influences outside of school that contribute to problem behaviors in adolescents need continued emphasis in prevention. Family-focused interventions (including parent training approaches that teach parents strategies to enhance compliant behavior, training in family skills, family therapy, and family self-help groups) are becoming increasingly important to consider for prevention of problem behaviors (30,56,57). The targeting of high-risk adolescents is also a promising approach to prevention that requires further investigation (53,58,59).

Finally, mental health professionals have a responsibility to provide research in the area of preventive mental health because only with such research can we learn what is helpful and effective in advancing the cause of prevention and treatment in mental health. Researchers from the Rand Corporation published a 1984 report that stated, "Our most optimistic conclusions are related to prevention — not because past . . . prevention programs have proven eminently successful, which they have not, but because we believe we know why past approaches have failed" (60). Program rationale, specification of observable and measurable program objectives, and detailed description of program evaluation, monitoring, and follow-up data should be a priority in documenting "the achievement of intended outcomes . . . [with a] defined, replicable set of procedures that [can] be adopted by practitioners" (59).

CONCLUSIONS

The field of prevention has become a burgeoning area of practice and research. Programs for prevention continue to need careful investigation into effective design and implementation. Future implementation of programs should be guided by an appreciation of those approaches to intervention that appear most effective in producing behavioral change, including intensive training in behavioral skills and comprehensive programs in school/community intervention. The effectiveness of these programs depends on consistent social and governmental support. The hope for the future is that concepts and efforts for prevention will continue to increase in sophistication and that replication of effective programs will become an essential ingredient in preventing problem behavior in adolescents.

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Overview: Measles outbreak on a college campus

James A. Zoretic, MD, MPH

Although the introduction of the measles vaccine in the United States in 1963 has led to a marked decrease in the incidence of measles (rubeola), this childhood exanthem has not been eliminated. Since 1983, increases in incidence have been observed. Outbreaks have occurred among previously immunized school and college-age students and unimmunized preschool children, infants, and babies. This article reports a measles outbreak at a state university in Texas and proposes a plan to develop immunity against measles to prevent future outbreaks at college and university campuses.

Send reprint requests to Dr Zoretic, Public Health Region 5, Texas Department of Health, 2561 Matlock Rd, Arlington, TX 76015-1621.

Measles (red measles, 10-day measles, rubeola, or hard measles) is an acute and highly contagious viral disease. It is generally self-limited but can be particularly severe, leading to higher morbidity and mortality for certain groups of individuals such as children younger than 2 years of age, chronically ill or malnourished children, and adults. Measles can produce severe respiratory and neurologic complications as a result of both disseminated disease and bacterial superinfections. Complications include pneumonia, otitis media, dehydration from diarrhea and/or vomiting, encephalitis, and even death.

Since 1988, there has been a substantial increase in the number of yearly cases of measles reported. During 1988, there were 3,396 cases reported; for 1989, there were 18,193 cases; and for 1990, there were 27,786 cases. A total of 49,375 cases were reported to the Division of Immunization, Center for Prevention Services, Centers for Disease Control (CDC) over the 3 years. This represents increases of 436% from 1988 to 1989 and 53% from 1989 to 1990. For 1990, persons from 15 through 24 years of age accounted for 5,646 cases (20.3%) (1).

Over a 78-week period from 1988 through mid-1989, complications were reported in 1,080 (10.5%) of 10,291 cases of measles. Otitis media was reported in 501 (4.9%); diarrhea, in 299 (2.9%); pneumonia, in 271 (2.6%); and encephalitis occurred in 9 (0.09%). Hospitalization was necessary in 1,281 (12.4%) cases, and 13 measles-associated deaths were reported, setting a case-fatality rate of 1.3 deaths per 1,000 reported cases (1,2).

For the period 1984 through 1988, the cases that occurred in children 10 years of age and older were 58% of the total as compared with 10% during 1960 through 1964. In recent years, two major types of outbreaks have occurred in the United States: first, cases among unvaccinated preschool children including those younger than the recommended age for vaccination and, second, cases among high school and college students and personnel on campuses. Most of the measles on college campuses were likely to have occurred in persons who had been vaccinated, although documentation of vaccination was often lacking (3).

In 1978, the Department of Health, Education, and Welfare established a goal to eliminate indigenous measles from the United States by October 1, 1982 (3), but this has not become a reality. The goal of eliminating measles in the United States will not be achieved in the near future partly because of the failure to implement current vaccination strategy and partly because of vaccine failure of the following types: primary vaccine failure, being an inadequate antibody response from the initial vaccination, and secondary failure, being an adequate response to the initial vaccination but with the subsequent loss of rubeola immunity in time, better known as "waning immunity."

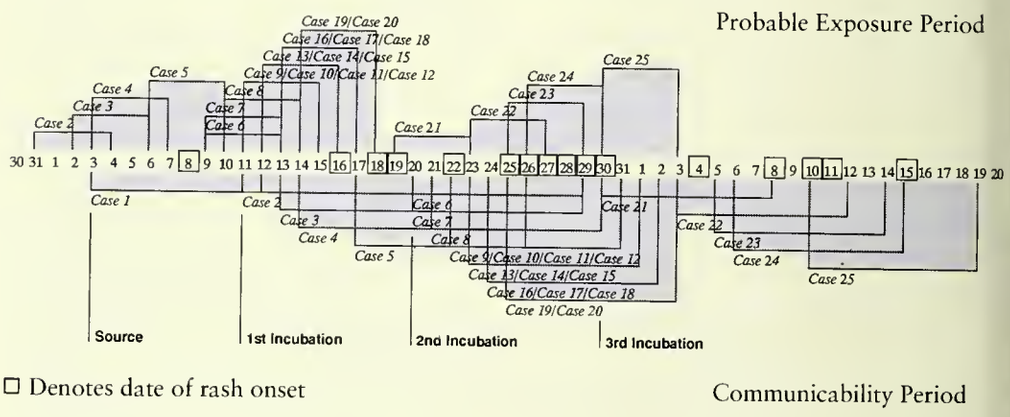
Between 1938 and 1963, before the first measles vaccine was licensed, the number of cases reported annually in the United States ranged from approximately 400,000 to 900,000 (4). By 1983, widespread immunization of infants and children had resulted in a 99% decrease in the incidence of measles. Since then, except for decreases in 1987 and 1988, cases have steadily increased among previously immunized school-age children, young adults,

and preschool children and infants (1). In the first 26 weeks of 1989, reported cases increased by 380% over the same period in 1988. A total of 3,520 (51.2%) of the patients with measles had been vaccinated on or after their first birthday. Most vaccine failures occurred in the group 12 through 19 years old (2).

The number of cases occurring in colleges and universities nationwide in the first 26 weeks of 1989 was 60.7% higher than that for the same period in 1988 (2). Of the more than 90 outbreaks that have been reported, most have occurred in secondary schools and colleges. Seventy-one colleges have reported at least one case of measles during the first 26 weeks of 1989 (1). Of the total measles cases reported in 1986 and 1987, college campuses accounted for 315 (3.2%). Overall, the individuals in 56.2% of the college cases in 1986 and 1987 were reported to have been appropriately vaccinated according to current recommendations.

In 1986, cases of measles were reported from colleges in 12 states; measles outbreaks with five or more cases occurred on five college campuses. In 1987, cases of measles at colleges were reported from 15 states, and outbreaks occurred on four college campuses. The largest college outbreak in 1987 occurred at Dartmouth College in New Hampshire. A total of 89 cases (63% of all 1987 college cases) occurred over five incubation periods between April and June 1987 (5). The incubation period for measles is approximately 10 days between invasion by the infectious agent and the appearance of the first signs and symptoms of the disease (Fig 1). In 1988, confirmed cases of measles that totaled in the hundreds for college-aged students were reported by 12 colleges and universities in Texas, according to the Immunization Division, Texas Department of Health (interoffice memo, April 10, 1989).

Fig 1. Times of exposure and communicability in an outbreak of measles at Tarleton State University, 1990.



☐ Denotes date of rash onset

CAMPUS MEASLES OUTBREAK REPORT

An outbreak of measles occurred at Tarleton State University in Stephenville, Tex, over three incubation periods between January 8 and February 15, 1990. The index case was in an 18-year-old female student who had not been vaccinated because of a false assumption that she had had the disease during childhood. The student was exposed most likely while working at a department store in her hometown of Waxahachie, 40 miles from Dallas, during the winter semester break, when the county of Dallas was experiencing a measles epidemic. She returned to campus only for 36 hours; however, this was sufficient time to infect the student body at Tarleton State University (TSU).

The TSU Health Center vaccinated 1,899 students and contacts on campus from January 24, 1990, to February 15, 1990. This represents approximately 30% of the student population. Most of the vaccines were administered during the first 2 weeks of the outbreak. All suspected measles cases reported to the Texas Department of Health, Public Health Region 5, Stephenville Field Office, or Tarleton State University Health Center from January through March were investigated using a standard measles case-reporting form. A case was defined as a person with a rash lasting at least 3 days and a fever of 38.3°C, along with either cough, coryza, or conjunctivitis (6).

The mode of transmission was primarily by droplet nuclei, but prolonged airborne transmission was suspected in a few cases where personal contact with a case could not be established. For six cases that had no known direct person-to-person contact with an infectious person, the mode of transmission was most likely by aerosolized mucous droplet suspension. This type of airborne transmission is possible because the measles virus can remain infective in aerosolized mucous droplets suspension for several hours under conditions of low humidity. This transmission occurs indirectly as well as by direct contact with respiratory droplets (7–9).

Table 1 presents data on age, sex, serologies or epi-links, symptoms, and hospitalization. The term "epi-link" is used to describe a case that was directly linked by an exposure to a known case with clinical disease during the period of communicability. The index plus 3 additional cases out of the 25 cases of measles were confirmed serologically, and 18 were linked by epidemiologic association. Two cases were possible vaccine reactions, however 1 had a viable epi-link. Two cases were of undetermined etiology.

Cases 10, 11, 17, 22, 24, and 25 had no direct epi-link to an individual case, either by classroom, dorm, or off-campus housing. Out of these six cases, four had possible links by other activities and one was a possible vaccine reaction. Case 11 dated the sister of the index case (Case 1) and knew the boyfriend (Case 2) of the index case. Case 11 was not sure about the date of last contact with either Case 1 or Case 2. It was thought that Case 2 would be the most likely source.

Case 22 was vaccinated on January 26, 1990. The symptoms started on February 8, 1990, and were less severe than those in other cases, and no direct contact was identified. This case was a possible vaccine reaction.

Case 24 was a bartender who worked at a campus establishment patronized by many students. She did not know of any other possible source for exposure. No other source of contact could be identified with this case.

Case 25 was a local worker who took company classes on the weekend at TSU during the time of the measles outbreak. These classes were determined to be a possible source for his infection.

In five cases of the six undetermined epi-link cases, the mode of transmission was apparently by airborne, aerosolized mucous droplets. In two of the cases, direct contact with a confirmed case was suspected but could not be substantiated.

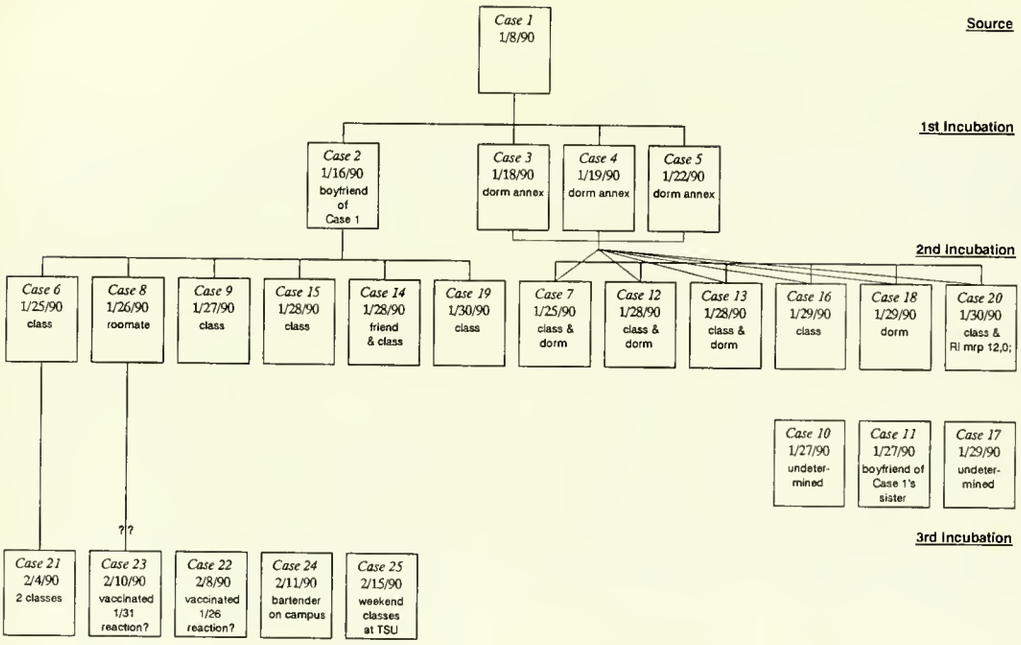
The outbreak at TSU is depicted in Fig 2, which shows the chain of transmission and the date of rash onset. There were 4 cases within the first incubation period, 15 cases within the second incubation, and 5 cases in the third incubation period.

Time of exposure and communi-

Table 1. Characteristics of cases with measles at Tarleton State University, 1990.

Case No.	Age	Sex	Epi-link or Serology	Cough	Coryza	Conjunctivitis	Koplik	Hospitalization
1	18	F	Igm+	•	•	•	•	•
2	19	M	Igm+	•	•			
3	20	F	Epi-link 1	•	•	•	•	
4	18	F	Epi-link 1	•		•		•
5	20	F	Epi-link 1	•	•	•		•
6	19	F	Epi-link 2	•	•	•	•	•
7	20	M	Epi-2, 3, 4, 5	•				
8	21	M	Epi-link 2	•	•	•	•	•
9	20	M	Epi-link 2	•	•	•		•
10	23	M	Igm+, undetermined	•	•			
11	20	M	? Link 1, 2	•	•	•		
12	18	M	Epi-2, 3, 4, 5		•		•	
13	18	F	Epi-2, 3, 4, 5	•	•	•	•	
14	21	M	Epi-link 2	•	•	•	•	
15	26	M	Epi-link 2	•	•			
16	24	M	Epi-2, 3, 4, 5	•	•	•	•	
17	21	F	Undetermined	•	•		•	
18	18	F	Epi-3, 4, 5	•		•		•
19	21	M	Epi-link 2	•				
20	18	F	Epi-2, 3, 4, 5	•	•	•	•	
21	18	F	Epi-link 6	•	•	•		•
22	21	F	? Vaccine reaction		•	•		
23	19	M	Epi-8 vs vaccine reaction	•	•	•		
24	24	F	Campus bar	•		•		
25	28	M	Igm+ weekend classes	•	•	•		

Fig 2. Chain of transmission and the date of rash onset in an outbreak of measles at Tarleton State University, 1990.



cability for all the cases are depicted in Fig 1. The date of rash onset for the index case was January 3, 1990, and the last case related to the epidemic at TSU occurred on February 15, 1990. The shaded areas in Fig 1 depict the confluent communicability and probable exposure periods.

Ages ranged from 18 to 28 years. The median age was 20 and the age with most frequent occurrence of measles was 18. Distribution was divided almost equally between the sexes: 13 male cases and 12 female cases.

Altogether, 7 students were hospitalized (5 females and 2 males), representing 28% of the total cases. Even though morbidity was higher than normal, no mortality was reported.

DISCUSSION

We must consider how many of these cases might have been prevented. The fact that the index case was unimmunized suggests that the entire outbreak could have been avoided if appropriate policies requiring proof of measles immunity had been in place at TSU. Many cases occurred in students with inadequate immunization histories or records. Many students in this age group developed clinical disease despite having been immunized in accordance with the recommendations in force at the time. This group at risk is for the most part unavoidable. But when these individuals are combined with those in a group for which the vaccine status is entirely unknown, the risk increases dramatically. The urgency for more rigid preventive strategies at TSU is underscored by the rate of complications and hospital admissions that occur as a result of measles in this age group.

The major reason for failure to eliminate measles in the United States is the lack of vaccination in people for whom it is recommended (3,5,7). Health-care providers employed by colleges and universities are responsible for preventing and controlling measles on campus. Vaccinating an entire university during an outbreak is expensive, time-consuming, and chaotic. Colleges and universities can contribute to the elimination of measles by requiring all susceptible employees and students to be vaccinated properly. Institutions of higher education need to adopt the new CDC recommendation for measles vaccination, which requires students or employees to show documentation of having received two doses of measles vaccine after the first birthday. The vaccinations should not be less than 1 month apart. If the individual has no documentation of any dose of vaccine, then vaccine should be given at the time of school entry or employment with an additional dose no less than 1 month later if no contraindication exists (3). The goal of eliminating measles on college and university campuses is unlikely to be achieved until this is accomplished.

The two-dose regimen for measles, mumps, and rubella was introduced in Sweden in 1982 for children aged 18 months and 12 years of age. This vaccination program was aimed at eliminating the three diseases and at avoiding a large number of adults being susceptible to these diseases. A Swedish study on the two-dose vaccination showed seroconversion to measles increased from 82% to 96% when tested by the hemolysis in gel method. Revaccination to previously vaccinated individuals prompts a rapid antibody response (10).

Besides adopting the new CDC recommendations, we must have accurate immunization and medical information on each employee and student. One alternative is requiring

high schools to submit a photocopy of their immunization records with each student's academic transcript. In this way, health center personnel would be able to screen incoming freshmen and transfer students before they enter college.

CONCLUSION

In view of the present situation in the United States, a routine measles booster with proper documentation for all children, students, and susceptible adults with proper documentation is necessary to eliminate this disease. Until adequate herd immunity levels are reached within the country, measles outbreaks will continue within immunized and unimmunized populations.

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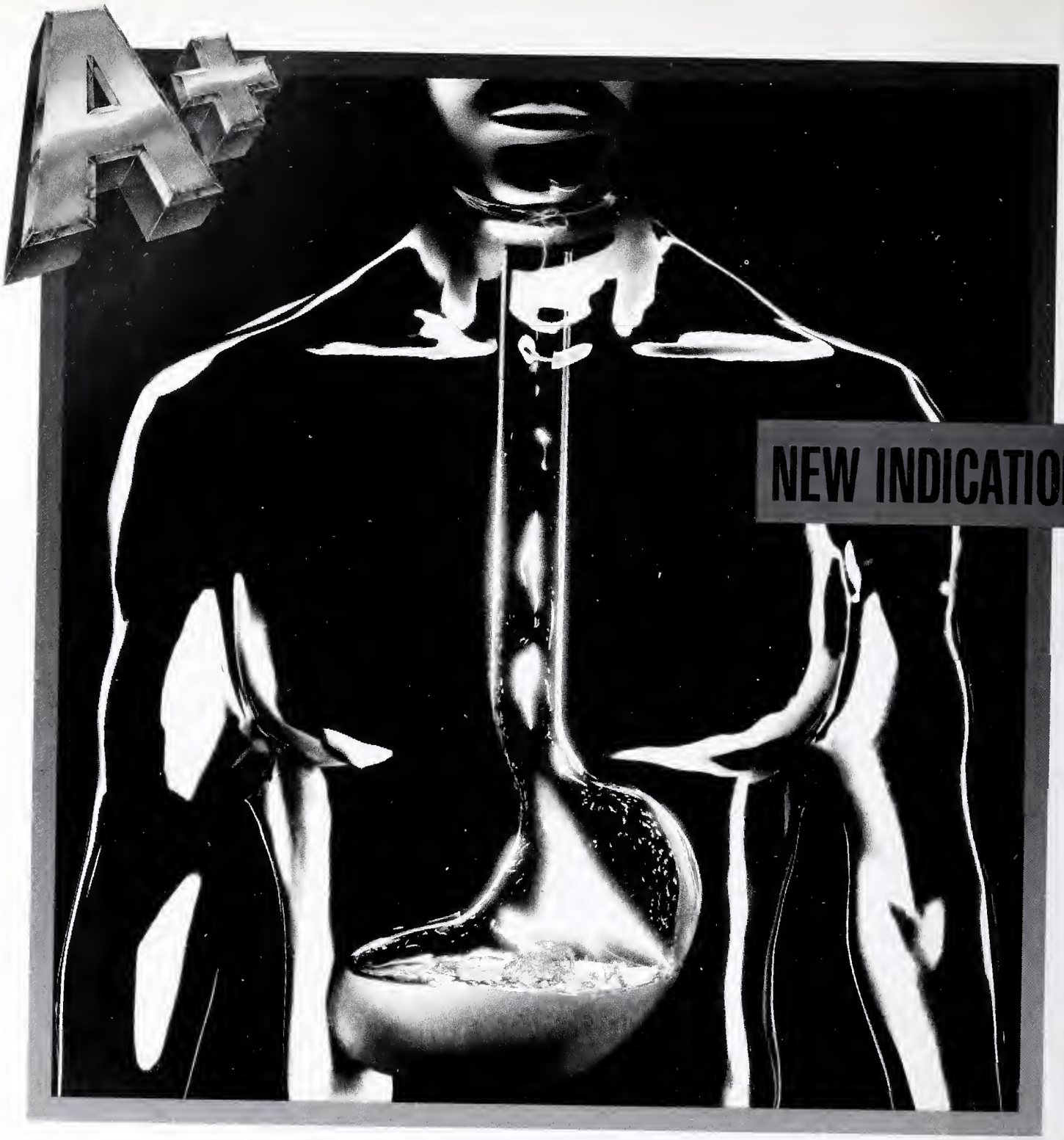

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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BE/BC radiation oncologist needed for cancer center in north central Texas community of approximately 24,000 (serving referral area of 195,000). Regional medical center with modern facilities and equipment. Incentive package. Area renown for recreational facilities. One hour from Dallas/Fort Worth metropolitan area.
Contact: Vicki Truitt.

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Contact: Barry Strittmatter.

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Orthopedic Surgeon, immediately busy practice near Houston, TX. Population base of 86,000; 75 miles southwest of Houston, TX. Has proven need for an Orthopedic Surgeon. Expected 1st year income in excess of $300,000. Hospital sponsored position with complete support of medical staff. Call coverage available. Excellent hunting and fishing. For details contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911 or 713 531-0911.

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Corpus Christi — Three physician group looking for BC/BE pediatrician to fill spot vacated by doctor who relocated out of state. Very busy, lucrative practice and still growing. Call or send CV to Len Leshin, MD, 3435 S. Alameda, Corpus Christi, TX 78411. 512 855-6257.

Pediatrics — Community 75 miles southwest of Houston recruiting to sponsor fourth pediatrician in town. Competitive income guarantee and relocation package, shared coverage. Stable economy, casual lifestyle. For details contact Practice Dynamics, 11222 Richmond, 125, Houston, TX 77082; 800 933-0911 or 713 531-0911.

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Radiologist — Part-time position, approximately 6 hours per weekday. No nights or calls on weekends. Send CV to: PPM, 1075, Kingwood Dr, Ste 204B, Kingwood, Texas 77339. 713 358-8113.

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College Station — Urologist needed to join a two-person group offering salary incentives and future buy-in, or go solo with income guarantee. Send CV to Gordon Crawford, Professional Relations, Humana Inc, Dept, TX3-2L, PO Box 1438, Louisville, KY 40201-1438. Or call Toll-Free 1-800-626-1590, ext. 134.

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Position Available — Seeking BC/BE Family Practice, General Internist, Endocrinologist, OB/GYN to join established multi-specialty clinic. Excellent benefits and guarantee. Send CV to Leroy W. Kitch, Administrator, Skinner Clinic, 124 Dallas St., San Antonio, TX 78205.

Northeast Texas — Two outpatient clinics. Forty hours per week. No call. No hospital practice. Affiliated with multi-hospital system in Tyler, Texas. Other opportunities in Tyler area for pediatrics and family practice requiring hospital practice. Call 903 569-6124. Resume: PO Box 908, Mineola, TX 75773.

Ambulatory Surgery Center in Dallas Texas seeking BC/BE internist or family practitioner to perform pre-op physical and to monitor pre-op patients. No weekends, call or evenings required. Salary 80K plus benefits. Benefit package includes medical, dental, and malpr tice insurance. Please send CV and photo to Dr. W man, 12308 Shiremont Dr., Dallas, Texas 75230.

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an Antonio, TX — Urgent Care Clinic with Family Practice setting for sale. Fast growing practice. Based on 65% fee-for-service/35% workman comp. No medicaid/medicare assignments or HMO. Excellent 3000 SF, NW location, loop 410. Contact F. Sanchez, MD 512 523-1411.

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CME / Continuing Education Directory

Courses

APRIL

Critical Care

Apr 22–26, 1992
Critical Care Update. Washington, DC. Contact Center for Bio-Medical Communication, 80 W Madison Ave, Dumont, NJ 07628 (201) 385-8080

Family Practice

Apr 29–May 3, 1992
Family Medicine Review. Austin. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

General Medicine

Apr 4, 1992
Diabetes and Thyroid Disease Update. Dallas. Contact St Paul Medical Center, Office of CME, 5909 Harry Hines Blvd, Dallas, TX 75235 (214) 879-3789

Apr 25, 1992
Teaching Day in Rheumatic Disease. Dallas. Contact St Paul Medical Center, Office of CME, 5909 Harry Hines Blvd, Dallas, TX 75235 (214) 879-3789

Oncology

Apr 1–4, 1992
Patterns and Mechanisms of Failure After Cancer Treatment. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Otolaryngology

Apr 23–24, 1992
Temporal Bone Mini Series. Galveston. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Pathology

Apr 25, 1992
What's New In Gastrointestinal Pathology. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Pediatrics

Apr 22, 1992
Management of Common Infections. Washington, DC. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Apr 23–25, 1992
Pediatric Infectious Diseases Seminar. Washington, DC. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Apr 24–25, 1992
Pediatric Postgraduate Symposium. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

Risk Management

Apr 9, 1992
Grand Rounds in Medical Malpractice. San Antonio. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Apr 11–12, 1992
Grand Rounds in Medical Malpractice. San Antonio. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Apr 26, 1992
Risk Management in the Pediatric Office. Washington, DC. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Surgery

Apr 30–May 2, 1992
Current Topics in General Surgery. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

MAY

Family Medicine

May 18–22, 1992
Review Course in Family Medicine. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

General Medicine

May 9, 1992
Cardiac Arrhythmias. Dallas. Contact S Paul Medical Center, Office of CME, 590 Harry Hines Blvd, Dallas, TX 75235 (214 879-3789

May 20–23, 1992
Controversies in Women's Health Care Acapulco, Mexico. Contact Scott & Whit Memorial Hosp, Office of CME, 2401 31st St, Temple, TX 76508 (817) 774-4083

Ophthalmology

May 16–17, 1992
Ophthalmic Practice Management Sympo sium. San Antonio. Contact Texas Oph thalmological Association, 401 W 15th St Austin, TX 78701 (800) 880-1300 o (512) 370-1504

Pathology

May 14–16, 1992
Current Issues in Surgical Pathology. Dal las. Contact The University of Texas Southwestern Medical Center, Office o CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

May 16, 1992
Fine Needle Aspiration Basic Tutorial. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

May 21–22, 1992
Current Issues in Anatomic Pathology. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

May 14–16, 1992
Advances & Controversies in Clinical Pediatrics. San Francisco. Contact Extended Programs, Rm LS-105, University of California School of Medicine, San Francisco CA (415) 476-4251

Risk Management

May 14, 1992
Grand Rounds in Medical Malpractice. Dallas. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

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ıy 19, 1992
and Rounds in Medical Malpractice. cAllen. Contact Medical Risk Manage-nt, Inc, 2500 City West Blvd, Ste 300, ›uston, TX 77042 (713) 789-6518

JNE

nergency Medicine

ne 10–11, 1992
nergency Care Update. Arlington. Con-ct CareFlite Fort Worth, 1301 Pennsylva-a Ave, Fort Worth, TX 76104 (817) 882-)10 or (800) 772-5840

›stetrics and Gynecology

ıne 18–19, 1992
iagnosis & Management of Lower Geni-l Tract Neoplasia. Contact The Universi- of Texas Southwestern Medical Center, ffice of CME, 5323 Harry Hines Blvd, allas, TX 75235 (214) 688-2166

phthalmology

ıne 11–13, 1992
ornea & Contact Lens Seminar. St Louis. ontact Washington University School of ledicine, Office of CME, 660 S Euclid Ave, t Louis, MO 63110-1093 (800) 325-9862

rthopaedic Surgery

une 5–7, 1992
Orthopaedic Surgery Review. Dallas. Con-act The University of Texas Southwestern Medical Center, Office of CME, 5323 Har-y Hines Blvd, Dallas, TX 75235 (214) 88-2166

Otolaryngology

une 11–13, 1992
Otolaryngology Update. Galveston. Con-act Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Pediatrics

June 15–19, 1992
Acute Care Pediatrics Review & Update. Hilton Head, SC. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

June 18–20, 1992
Pediatric Review & Update. Galveston. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Plastic Surgery

June 4–7, 1992
Advances in Aesthetic & Reconstructive Breast Surgery. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Urology

June 26–28, 1992
Frontiers in Endourology: Laparoscopic Nephrectomy & Beyond. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

JULY

General Medicine

July 2–4, 1992
Highlights in Women's Health Care. Santa Fe, NM. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

July 17–19, 1992
Caring for the Aging Population: Knowledge & Skills for the Primary Care Physician. San Francisco. Contact American Geriatrics Society, 770 Lexington Ave, Ste 300, New York, NY 10021 (212) 308-1414

Obstetrics and Gynecology

July 11–13, 1992
Issues in Care: Ob-Gyn. South Padre Island. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Ophthalmology

July 24–25, 1992
PHACO 1992. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Calendar of Meetings

•Denotes Texas meeting

March

Mar 4–6, 1992, Houston
•*Texas Association of Obstetricians & Gynecologists Annual Meeting*
Contact Terrence Kuhlmann, MD, 1007 E 41st St, Austin, TX 78751 (512) 451-3131

April

Apr 2–4, 1992, San Antonio
•*Texas Urological Society Annual Meeting*
Contact TUS, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1526

Apr 2–5, 1992, Houston
•*Texas Radiological Society Annual Meeting*
Contact TRS, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1507

May

May 14–17, 1992, San Antonio
•Texas Medical Association Annual Session
Contact TMA, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1450

May 16–17, 1992, San Antonio
•*Texas Society of Anesthesiologists Interim Meeting*
Contact TSA, 401 W 15th St, Ste 990, Austin, TX 78701 (512) 370-1659

September

Sept 11–13, 1992, El Paso
•*Texas Society of Anesthesiologists Annual Meeting*
Contact TSA, 401 W 15th St, Ste 990, Austin, TX 78701 (512) 370-1659

Sept 19, 1992, Austin
•Texas Medical Association Fall Leadership Conference
Contact Jon Hornaday, 401 W 15th St, Austin 78701 (800) 880-1300 or (512) 370-1345

November

Nov 18–21, 1992
•*American Association for Cancer Education*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Find Solutions at

Annual Session ◆ General Sessions ◆ Saturday, May 16

The Public Image of the Physician

Find out how to heal the doctor's image

- Dennis Johnson, medical reporter, WFAA-TV, Dallas
- Edward E. Rosenbaum, M.D., author of "The Doctor"
- Joseph W. Synan, M.D., leadership consultant
- Steve Booton, M.D., physician-patient communication consultant

What's In, What's Out in Medicare... Discussion With the Experts

Find the latest on RBRVS and improving third-party reimbursement

- Angela Vierville, medical reporter, KSAT-TV, SanAntonio
- J. Michael Hudson, Deputy Administrator, Health Care Financing Administration
- Harold Whittington, medical practice consultant

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Environmental Encounters

what primary care physicians need to know

"Find the answers in San Antonio" at TMA's Annual Session / 13, 24 • New Medicaid payment system begins April 1 / 46 • Neonatal transport in Texas / 66

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TEXAS MEDICAL ASSOCIATION

A PUBLICATION *of the* TEXAS MEDICAL ASSOCIATION

TexasMedicine

APRIL 1992 • VOLUME 88 NO. 4

Cover illustration by Scott Baldwin.

Texas Medicine Feature

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"The public looks to physicians as reliable sources of information, particularly in the area of the environment." — Ralph D. Morris, MD

Environmental encounters: What primary care physicians need to know

Where your patients live, work, and play may help you diagnose an environment-related illness.

BY LAURA J. ALBRECHT

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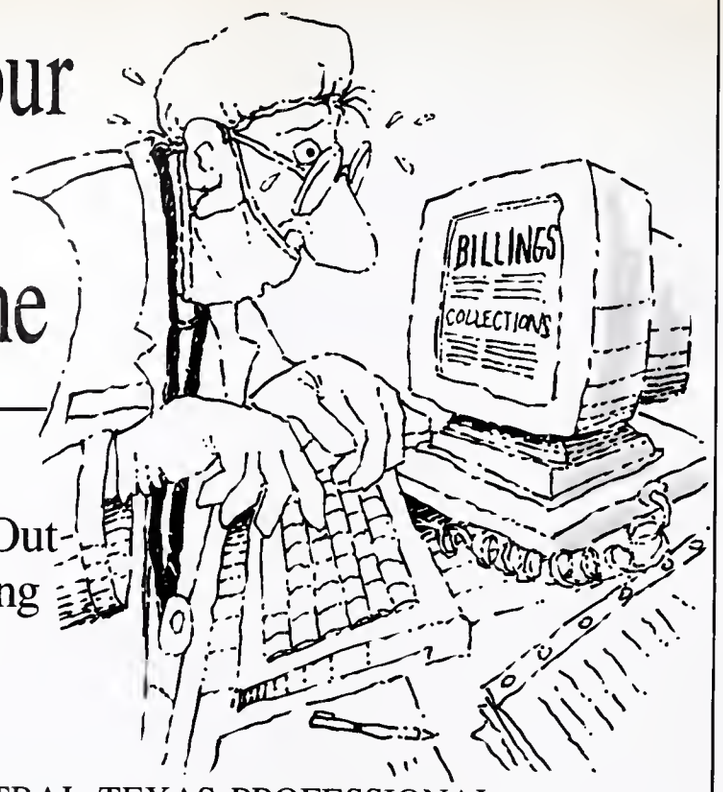

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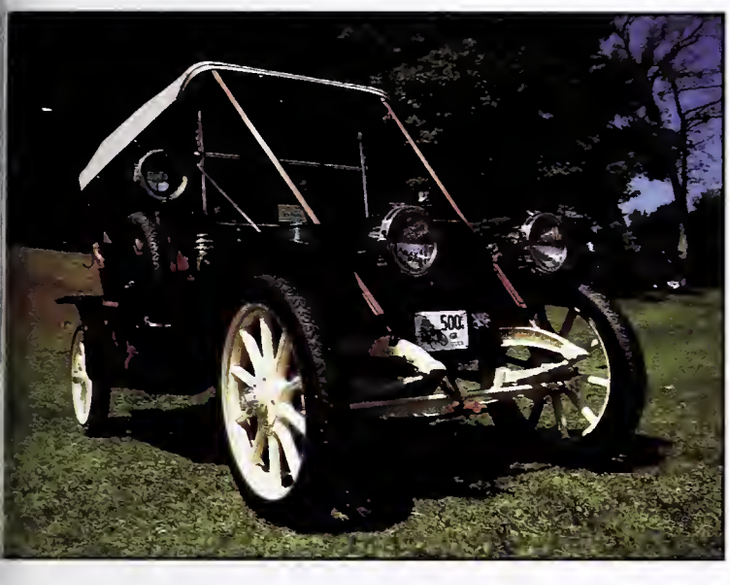

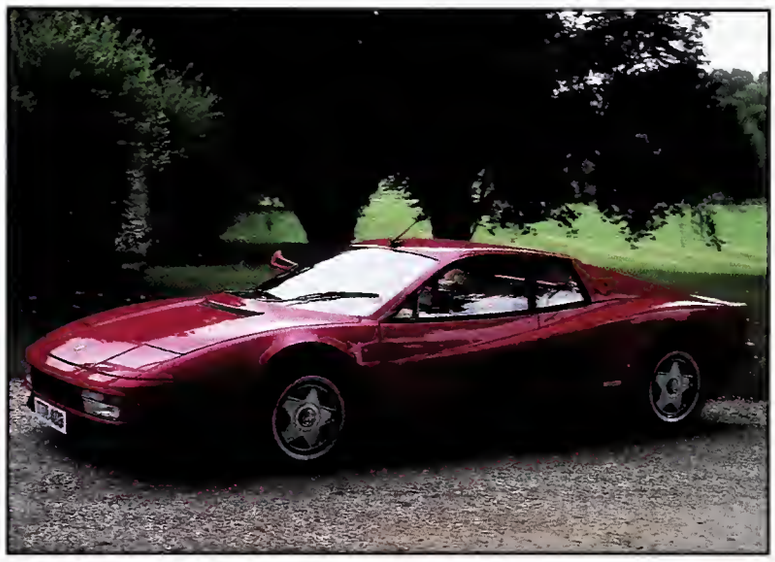

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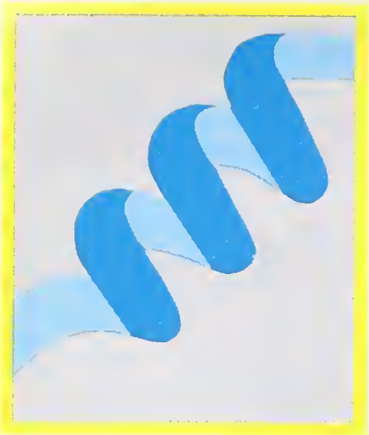

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Letters

C/BS's new program raws criticism

BECAUSE MY OFFICE HAD many concerns about ParPlan — the new program introuced by Blue Cross and Blue Shield f Texas and announced in *Texas Iedicine* (November 1991, pp 1–32 and January 1992, pp 65–66) – I contacted Blue Cross.

Among the points I raised were:

- A contractual relationship between physicians and third parties is onerous and damaging to patient-physician relationships. A physician's contract must be with the patient.
- ParPlan appears to be a reintroduction of Medicare's participating or nonparticipating proposal of years ago. The indemnity approach to medical care and third-party payments would be further damaged by ParPlan.
- The annual evaluation of fees promised by ParPlan is neither a guarantee nor even an assurance that physicians' rising costs of practice will be taken into consideration.
- Precertification is a major hassle factor and drain on physicians' office personnel and it is not generally deemed cost-effective. Further, any single, toll-free line would, more than often, be busy, and once the customer service division is reached, we could expect to be put on hold for an inordinate amount of time.
- ParPlan's policy of sending funds directly to a patient when the physician rendering a service does not participate in ParPlan is a great disservice to physicians. This strongly limits access to care and is a violation of the principle of "assignment of benefits."
- Blue Cross & Blue Shield of Texas and New Mexico tried an HMO some years ago that was a dismal failure. I agree with the management of American Airlines that HMOs are not a cost-effective way to deliver medical care.
- Neither medicine nor our patients, to whom we offer caring, competent medical services, are best served by programs such as ParPlan. My office will pass this time around.

I have yet to receive any response from Blue Cross and Blue Shield.

R.A.D. Morton, Jr, MD
Curie Medical Building, Suite 100
1733 Curie
El Paso, TX 79902

Rural Health Clinic Program draws further comment

I READ WITH INTEREST YOUR article, "Physicians say some hospital corporations abuse Rural Health Clinic Program," (*Texas Medicine*, January 1992, pp 60–62).

We have experienced a similar situation in Burnet, where an RHC opened and is competing directly with local physicians for patients. We welcome competition, but as the president repeats so often, we want a "level field," not competition subsidized by our taxes!

I feel that the RHCs are a back door to socialized medicine and TMA has underestimated the situation badly. Today, we establish RHCs on government salaries; next we all will be employed by the government!

I hope it's not too late to reverse our support for socialized medicine in the United States. After all, this didn't work too well in the former USSR. Do we ever learn?

John Garwacki, MD
Shepperd Medical-Surgical Clinic
PO Box L
Burnet, TX 78611

(Editor's note: The following letter was written in response to a mention in the RHC article of a physician who had left Texas for Oregon because of his frustrations with RHCs.)

I HATE TO SEE PHYSICIANS moving from Texas to Oregon and other states. There are plenty of opportunities in East Texas. Come to Marshall, and we will treat you right.

George E. Bennett, MD
402 S Bolivar
Marshall, TX 75670

Providing charity care may help prevent national health insurance

MUCH HAS BEEN WRITTEN recently about the so-called health-care crisis in the United States. Two principal factors have precipitated this debate. First, many citizens — some working and some unemployed — do not have health-care insurance. Second, insurance companies are covering (or not covering) individuals and groups based on risk profiles or preexisting conditions.

We physicians can address the first problem in our own offices. While we can do little or nothing about a lack of hospitalization insurance, we can certainly provide care based on an ability to pay. Is there any physician who would turn away someone who needed care but could not pay for it?

If we do not want a national Medicare plan for everyone, then we need to address within our own offices the problems of patients who do not have health insurance. We can also try to help those whose insurance policies exclude preexisting conditions or refuse to pay because treatment may be "inappropriate."

Many years ago, we physicians cared for those less fortunate without regard to payment. Patients sometimes paid with baskets of fruit, or a chicken, or a bushel of corn. In modern times — and I think largely because of Medicare — we don't provide much charity care. Perhaps it is time to do so again.

If we do not care for those in need, we will have national health insurance. If we do care for them, we will have taken away the bureaucrats' excuse for telling us how to practice medicine.

I realize that some physicians could become overburdened with an excess of charity cases and that a single charity case could take an inordinate amount of time. But if a system could be developed, either through state or county medical societies, then patients could be spread evenly about the medical community. I would suggest a well-publicized system such that someone in need could call, for example, a county medical society to get a referral, on a rotating basis, to the physician best qualified to care for the needs of the caller. Perhaps we could even set up a tax-exempt foundation to partially pay for indigent care in our offices.

I realize there are no easy solutions. But, as I watch television and read the newspaper and news magazines, it appears we physicians are sitting idly by while bureaucrats, labor unions, and large and small employers formulate a new system of health care in this country without our input. It is time we did our duty to our patients and solved the problems ourselves.

Larry W. James, MD
11770 Jollyville Rd
Austin, TX 78759

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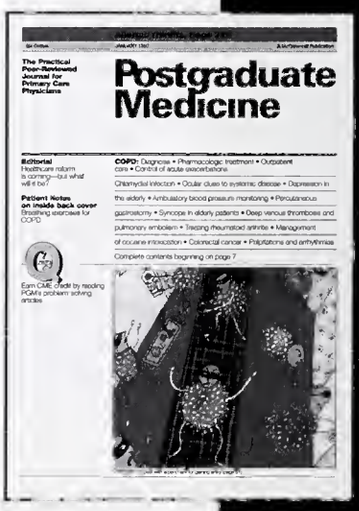

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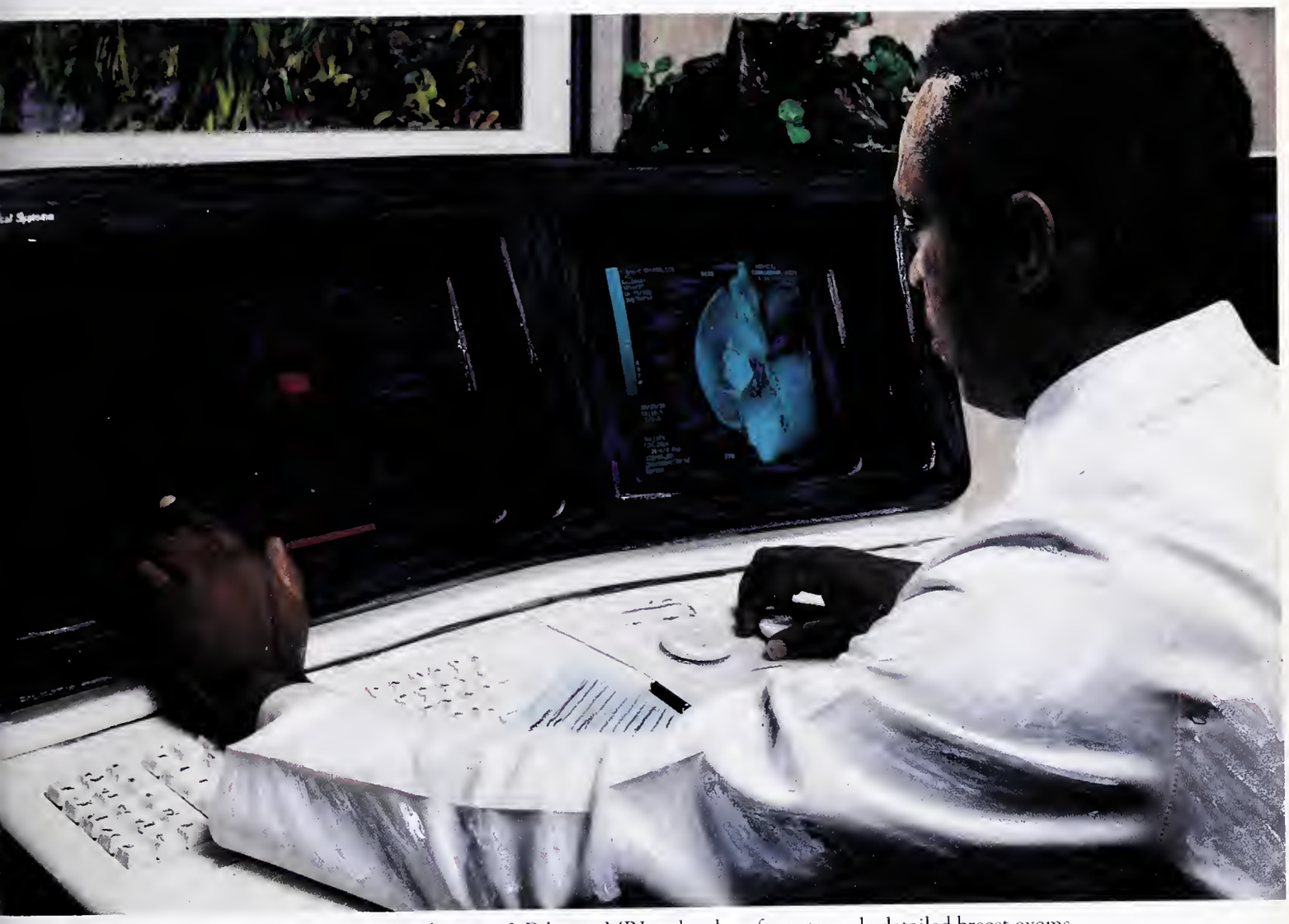

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Upfront

Annual Session heads for San Antonio

WITH ITS FOCUS ON problems commonly encountered by the primary are physician — from sleep disorders to sports injuries to gastroesophageal reflux disease and much more — the 1992 TMA Annual Session in San Antonio was designed to make a real difference in your daily practice (see box for a partial list of guest speakers).

Two articles in this issue of *Texas Medicine* provide a glimpse of some of the sessions planned for the May 14–17 meeting. "'Find the answers' in science symposia at TMA Annual Session," pp 24–26, highlights programs on women's health issues, the medical family, environmental issues in primary care, and medicine and the law. For a closer look at environmental issues, see "Environmental encounters," pp 38–44.

And, although most physicians attend Annual Session for its "science" aspects, the meeting's "nonscience" aspects also deserve notice. Among those scheduled are:

- Sports events, including a golf tournament, a self-scheduled and self-paced fun run through San Antonio's Riverwalk, and a tennis tournament.
- An automobile show, sponsored by the Bexar County Medical Society in conjunction with TMA.

Guest speakers distinguish Annual Session programs

AMONG THE GUEST SPEAKERS planned for TMA's 125th Annual Session are:

Stephen Barrett, MD
Allentown, Pa
Health schemes, scams, frauds

Curtis L. Baysinger, MD
Columbia, SC
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Irving N. Berlin, MD
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Child and adolescent psychiatry

Charles D. Bluestone, MD
Pittsburgh, Pa
Pediatric otolaryngology

William W. Campbell, Jr, MD
Richmond, Va
Neurology

E. Shannon Cooper, MD, JD
New Orleans, La
Medical-legal aspects of blood transfusions

Arthur L. Day, MD
Gainesville, Fla
Neurological surgery

Thomas W. Gardner, MD
Hershey, Pa
Ophthalmology

Martin J. Gaynes, JD
Washington, DC
Federal impact on medical practice

Bernard D. Goldstein, MD
Piscataway, NJ
Environmental medicine

Kenneth E. Greer, MD
Charlottesville, Va
Dermatology

Michael F. Hartshorne, MD
Albuquerque, NM
Radiation emergencies

Renee M. Hartz, MD
Chicago, Ill
Coronary artery disease in American women

Victor D. Herbert, MD, JD
Bronx, NY
Legal and medical aspects of cancer

James G. Hoehn, MD
Albany, NY
Plastic surgery

William V. Huval, MD
West Palm Beach, Fla
Colon and rectal surgery

Peter A. Indelicato, MD
Gainesville, Fla
Orthopedics/sports medicine

Kenneth D. Johnson, MD
Nashville, Tenn
Orthopedic trauma

Jordan S. Josephson, MD
Brooklyn, NY
Otolaryngology

Jerry M. Lewis, MD
Dallas, Tex
Medical marriages

Peter McKinney, MD
Chicago, Ill
Plastic surgery

Sydney J. Peerless, MD
Miami, Fla
Neurological surgery

Vivian W. Pinn, MD
Bethesda, Md
Research for women's health

Richard K. Reznick, MD
Toronto, Ontario, Canada
Colon and rectal surgery

E. Chester Ridgway, MD
Denver, Colo
Endocrinology

Barry W. Rovner, MD
Philadelphia, Pa
Geriatric psychiatry

Owen M. Russell, MD
San Antonio, Tex
Flight safety

Melvin Schapiro, MD
Los Angeles, Calif
Gastroenterology

Paul H. Toffel, MD
Los Angeles, Calif
Otolaryngology

Bailus Walker, Jr, PhD, MPH
Oklahoma City, Okla
Occupational and environmental health

A variety of new cars will be displayed, and manufacturers' representatives will be on hand to answer questions. The show will be held in the north exhibit hall during regular exhibit hours.

- A physicians' arts and crafts exhibit, displaying the work of TMA members in the exhibit hall May 14–16.

If you register for Annual Session by April 22, your name will be entered in the following drawings: a weekend for two at the Marriott Riverwalk; a luncheon ticket for the Annual Membership Luncheon; brunch for two (Sunday) at the La Mansion del Rio; tickets for two to the TMA/TMAA Friday night social event, "A Night in Old San Antonio"; one night for two at the Hilton Palacio del Rio; one night for two at the Marriott Rivercenter; and a $25 gift certificate at the Little Rhine Steakhouse.

Check your 1992 Annual Session Advance Program for further details or to register. Call (800) 880-1300 or (512) 370-1451 if you would like another copy.

NATIONALLY KNOWN SPEAKERS HEADLINE AUXILIARY ANNUAL CONVENTION

CHOSEN FOR THEIR MESSAGE'S appeal to physicians *and* spouses, th highlight speakers at the TMA Auxiliary annual convention, Ma 13–15 in San Antonio, represent a wide array of topics:

- **Roy W. Menninger, MD,** and his wife, **Beverly Menninger,** of the renowned Mer ninger Clinic in Topeka, Kan, will present a seminar on medical marriag Friday, May 15, from 9 to 11 am. Dr Menninger is president of the Mer ninger Foundation and coeditor of *Medical Marriages* (American Psych atric Press, 1988). The Menninger Clinic frequently treats physicians, thei family members, and family relationships.
- Popular speaker, author, and physician, **Ferrol Sams, MD,** will present "Re capturing the Joy of Medicine," Thursday, May 14, at a noon luncheon As a practicing physician in the small town of Fayetteville, Ga, Dr Sam has drawn from experiences with his practice to publish seven successfu books, including his first, *Run With the Horsemen.*
- **Sarah Weddington,** the attorney who argued the winning side of the land mark *"Roe v Wade"* case, will speak at a noon luncheon, Friday, May 15 A longtime advocate for women, Ms Weddington was the first woma elected from Austin to the Texas House of Representatives. She will speal about "Some Leaders are Born Women."

Tickets for each of the speakers are $25. For further information abou the Auxiliary annual convention or to order tickets, contact the TMA Auxil iary at (800) 880-1300 or (512) 370-1328.

National health policy expert speaks about plan for healthy Americans

WHEN J. MICHAEL MCGINNIS, MD, talks about health, it is the health of *all* Americans that concerns him. As assistant secretary of the US Department of Health and Human Services and primary author of the department's major study, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, Dr McGinnis is a ready source of information about the health of US citizens.

But it was to discuss strategies for *improving* Americans' health that Dr McGinnis came to Austin February 19 for a presentation at the Texas Medical Association headquarters.

After discussing the impressive degree to which the 1990 national goals for improving Americans' health were met, Dr McGinnis stressed that the focus within the US Public Health Service continues to be on disease prevention and health promotion.

He identified the leading causes of death in 1989 — heart dis ease, cancer, cerebrovascular disease unintentional injuries, chronic lun disease, pneumonia and influenza, di abetes, suicide, chronic liver disease cirrhosis, and kidney disease — bu then discussed the degree to whic the *real* causes of death were behav ioral or life-style factors, such as to

J. Michael McGinnis, MD, spoke about national health objectives to an audience of Texas physicians and public health officials.

J. Michael McGinnis, MD, left, and R. Palmer Beasley, MD, Houston, discuss public health policy. Dr Beasley is cochairman of the Health Prevention/Health Promotion Task Force of the Texas Higher Education Coordinating Board and dean and professor of epidemiology at the School of Public Health, The University of Texas Health Science Center at Houston. Dr McGinnis serves as consultant to the task force.

ıcco, alcohol, and other drug use.

As an example of the relative ›ntribution of risk factors, Dr ſcGinnis estimated that life-style :counted for about 54% of the ortality of heart disease, heredity ›out 25%, environmental factors ›out 9%, and lack of access to ap- ropriate health care about 12%. milar percentages applied, he said, › cancer and stroke.

One point that physicians should alize about these risk factors, said r McGinnis, is that the great ma- ›rity of the causes of premature ıortality comes not from factors ıat are directly controllable by hysicians, but from life-style, eredity, and environmental factors. ı fact, he estimated that the health- ıre factor contributes directly to nly about 10% of the risk for the ıding causes of death.

In enumerating the health goals ›r the nation by the year 2000, Dr ſcGinnis identified three primary ›cuses:

- increase the span of healthy life for Americans;
- reduce health disparities among Americans; and
- achieve access to preventive services for all Americans.

He pointed out that while im- roved access to health care could ot by itself insure the health of ımericans, for many citizens finding primary care physician was a roblem. He emphasized the need ›r more primary care physicians, specially in Texas, with its larger ercentage of children who need ealth care.

TMA honors journalists who convey health information

THIRTY-SEVEN TEXAS WRITERS and broadcasters have been selected by Texas Medical Association for recognition through its Anson Jones Award competition, which honors excellence in communicating health information to the public.

Awards consisting of a framed certificate and a $500 cash prize will be presented to 16 winners during the TMA Annual Session in San Antonio, Saturday, May 16. Twenty-one journalists will receive Citations of Merit.

Established in 1957, the award program recognizes journalism that contributes to a better public understanding of medicine and health in Texas through newspapers, magazines/newsletters, radio, and television. A new category recognizes Spanish language reporting. Another category, new last year, recognizes stories on medical economics.

The winners are:

Daily newspapers with 100,000+ circulation — *The Dallas Morning News*; Susan K. Levine, assistant metropolitan editor; "Resurrection."

Daily newspapers with circulation between 24,000 and 99,999 — *The Galveston Daily News*; Bob Whitby, reporter; "Sex Change Operations." *Lubbock Avalanche-Journal*; Valerie Ullman Avery, medical writer; "Small Lives, Big Choices."

Weekly, biweekly, or semiweekly newspapers — *Cutlass*, Pine Tree High School, Longview; Patricia Story, adviser; "Strohsahl Promotes Sexual Awareness for Everyone During SAFE Week."

Magazines/newsletters (company, employee, association, trade, or chamber) — *Seven-Up Leader*, Dallas, Bridget Barry, editor, corporate communications; "Keeping the Faith."

Magazines/newsletters (consumer, general interest) — *Texas Monthly*; Joe Holley; "Voices from the Dark." *Texas Monthly*; Dana Rubin, associate editor; "Calm After the Storm."

Radio stations in Dallas, Fort Worth, Houston, San Antonio, and Austin — WOAI, San Antonio; Jim Forsyth, news reporter; "To Live Again."

Television stations in Dallas, Fort Worth, Houston, San Antonio, and Austin — KTBC, Austin; Stephanie Winn, health reporter; "Breast Cancer: Breaking Through Denial." KPRC, Houston; Ann Davis, producer; "Breast Cancer: Every Woman's Fear."

Television stations in other locations — KDBC, El Paso; Chris Heinbaugh, producer; "AIDS on the Border."

Socioeconomics of medicine/large market — *San Antonio Express-News*; Bill Hendricks, staff writer; "Private Psychiatric Hospitals."

Socioeconomics of medicine/other locations — *Waco Tribune-Herald*; Lynn Bulmahn, staff writer; "Condition Critical: Health Care in America."

Spanish language — *El Paso Times*; Denise Bezick, reporter, and Paul Salopek, special projects writer; "Cholera." KUVN-TV, Garland; Monica Hirst, news director; "Su Embarazo: Cuidando el Futuro."

The Anson Jones Award is named for a pioneer Texas physician who served the Republic of Texas with distinction as a member of Congress, secretary of state, and its last president. He was responsible for establishing the first regulations concerning the practice of medicine in Texas. He also urged formation of an "Association of Physicians of the Republic of Texas for the promotion and general diffusion of medical knowledge."

COMMENTARY

"Dear Doctor in the year 2040"

Barry W. Uhr, MD
President, Dallas County Medical Society

ECONOMIC FORCES ARE changing the delivery of medical care. It will never be the same as we have known it. Those changes started many years ago when a third party assumed the payer role, placing itself between the patient and the physician. Those who have known it the way it was are going through a grieving process.

You have heard more on that topic than you probably want to. I do not intend to add to your anxieties. Medicine will survive, but I wish to take you on a brief journey to help us through our grieving.

Here I am, a medical romantic with dreams of what medicine should be and memories of what it has been. I am just another in a long line of physicians to whom our profession is special and one who is concerned about the changing image that touches us all.

See if you agree with a physician's letter to the future:

Dear Doctor in the year 2040:

I am writing you this letter in 1992 because I will not be around in your time. I may be one of your guardian angels.

Yes, all physicians have them. No, you cannot dismiss them. The lineage of medicine goes back thousands of years and all ethical physicians are angels on our shoulders and will be on yours.

I am sending you this letter so you may have a better understanding of your past. Then, perhaps, you will be able to put things into a better perspective. If I have predicted correctly, your system of medical care delivery will be less personal than mine and that concerns me.

In my early years, we had a very personal relationship with our patients. They selected us as individuals, not because we were a member of a particular provider group. We enjoyed a one-to-one trusting relationship. Can you even imagine what that individual relationship meant to us? It was more rewarding than any monetary gain.

That is changing even as I write this letter, and these changes are being driven by economics and technology.

The government probably pays you a salary now and the patient's allegiance is to the payer and not to his physician.

In my time, we have seen a change in the public's perception of medicine. Advertising and promotion changed the image of the physician. People became fascinated with technology and began to trust in it, more than in the physician. The loss of that trust was difficult for us to accept because of our basic commitment as advocates for our patients.

I suspect you have a much less intense role in taking care of patients than I. Technicians probably deliver most medical care, diminishing your role as a physician. That is the nature of technology.

Because you have not been without them, I'll bet you do not even realize that the classic role of a diagnostician has been usurped by technological advances such as computerized diagnostic analysis and treatment programs, robotic imaging scanners, and automated laboratories.

Surgical procedures using computer directed lasers, and the implantation of artificial organs and limbs should be commonplace. Genetic engineering has probably eliminated many physical defects and diseases that I could only ameliorate.

Those technologies, born in my lifetime, are undeniable scientific wonders.

But where do they leave you as a physician? What is it that you can offer to validate your profession?

Perhaps you have feelings of being a part of something larger than yourself. Those are the feelings we all share. They emanate from the spirits of gentle giants of medicine coursing through our veins.

They are what we have always been about: the touching of a hand, the gazing into eyes, and the comforting voice of a physician saying,

I dream your dreams;
I perceive your pain;
I share your mortality;
Therefore I understand.

Thus, the domain of the physician is not restricted to the physical being as is technology. You are allowed beyond that temporary temple. You have access to the spirit.

As a healer of the body, you have been superbly trained. As caretaker of the spirit, you must preserve a personal relationship with patients . . . for to touch another body with healing hands may be your job, but to instill hope is to continue the heritage of our profession.

We are counting on you. ★

Editor's note: This commentary is a reproduction of the text of Dr Uhr's speech when he was installed as president of the Dallas County Medical Society in January.

Now...

WHEN DEPRESSION KEEPS YOUR PATIENTS OUT OF THE MAINSTREAM

MOVE FORWARD WITH CONFIDENCE

ONCE-A-DAY

NEW **Zoloft**™

(sertraline HCl) 50 mg, 100 mg scored tablets

Please see brief summary of prescribing information on last page of this advertisement.

NOW, IN DEPRESSION MANAGEMENT...

ONCE-A-DAY

NEW **Zoloft**™

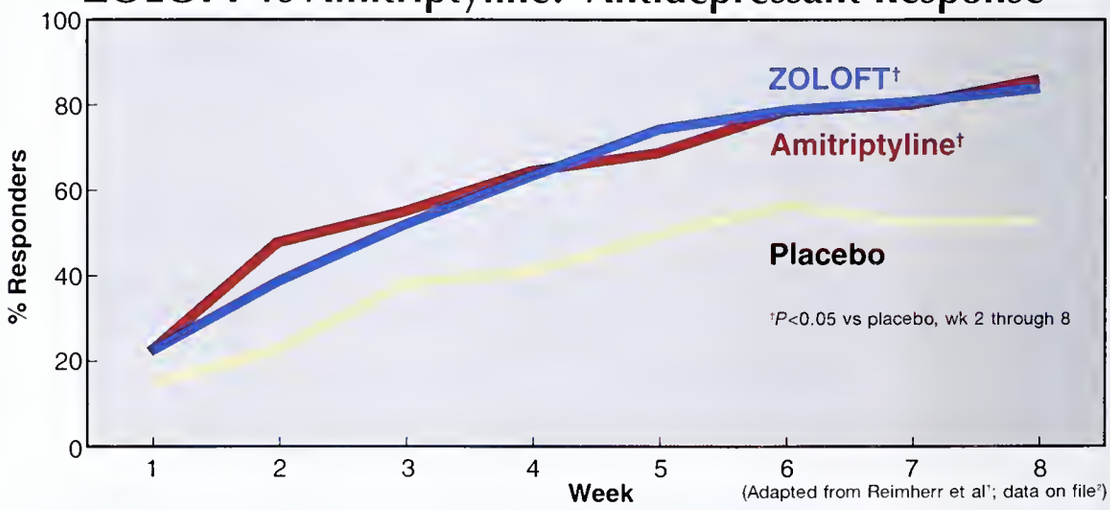
(sertraline HCl) 50 mg, 100 mg scored tablets

GETS DEPRESSED PATIENTS BACK INTO THE MAINSTREAM

- ZOLOFT, a new selective serotonin reuptake inhibitor, improves mood and enhances patients' ability to function
- ZOLOFT effectively reduces depressive symptoms, which may include dysphoric mood, loss of interest or pleasure, increased fatigue, and psychomotor agitation or retardation

ZOLOFT...Effective in the Treatment of Depression

ZOLOFT vs Amitriptyline: Antidepressant Response*[1,2]



(Adapted from Reimherr et al[1]; data on file[2])

*Observed cases, evaluable patients (ie, patients who took drug on or after double-blind treatment day 11 and who had efficacy evaluations within that same time frame); response is defined as a CGI-Improvement score of 1 (very much improved) or 2 (much improved) at time point. Patient numbers for each regimen: ZOLOFT—wk 1=117, wk 2=120, wk 3=106, wk 4=98, wk 5=93, wk 6=94, wk 7=83, wk 8=80; amitriptyline—wk 1=116, wk 2=113, wk 3=111, wk 4=104, wk 5=102, wk 6=92, wk 7=89, wk 8=76; placebo—wk 1=124, wk 2=120, wk 3=116, wk 4=108, wk 5=97, wk 6=89, wk 7=94, wk 8=85.

Double-blind, multicenter, placebo-controlled, parallel study of antidepressant effects of ZOLOFT vs amitriptyline in 448 subjects who met DSM-III criteria for major depression. Symptoms were assessed after a single-blind, 7-day to 14-day placebo washout. Patients were randomly assigned to ZOLOFT, amitriptyline, or placebo for 8 wk. Daily dosage ranges: ZOLOFT—50-200 mg; amitriptyline—50-150 mg.

© 1992, Pfizer Inc

ZOLOFT...Effective Continuation Therapy[2,3]

- Responders to ZOLOFT during an 8-week acute-treatment phase were randomized to continue on ZOLOFT or placebo
- A significantly lower relapse rate* was observed for patients treated with ZOLOFT compared with those on placebo, in an assessment of the first 8 weeks of the continuation period
- The effectiveness of ZOLOFT has not been systematically evaluated in long-term use for more than 16 weeks

ZOLOFT...Physician and Patient Confidence

- Low risk of toxicity in overdose
- ZOLOFT has a lower incidence of tricyclic-like side effects and a low incidence of nervousness, anxiety, and agitation
- The most common side effects of ZOLOFT include nausea, diarrhea or loose stools, tremor, insomnia, somnolence, and dry mouth

ZOLOFT...Once-Daily Dosing May Enhance Patient Compliance

- ZOLOFT is available in 50-mg and 100-mg scored tablets for flexible, once-daily dosing
- ZOLOFT can be taken in the morning or evening, with or without food

*Relapsing patients were those who became ill (CGI-Severity score ≥4 at any visit) during the double-blind continuation phase and who remained ill during the rest of their time in the study.

Responders in an 8-wk, open-label, acute-treatment study entered a double-blind continuation phase and were randomized to ZOLOFT or placebo. ZOLOFT daily dosage range: 50-200 mg.

References: 1. Reimherr FW, Chouinard G, Cohn CK, et al. Antidepressant efficacy of sertraline: a double-blind, placebo- and amitriptyline-controlled, multicenter comparison study in outpatients with major depression. *J Clin Psychiatry.* 1990;51(12, suppl B):18-27. **2.** Data on file. Pfizer Inc, New York, NY. **3.** Doogan DP, Caillard V. Sertraline in the prevention of depression. *Br J Psychiatry.* 1992;160:217-222.

Please see brief summary of prescribing information on adjacent page.

ONCE-A-DAY

Zoloft™

(sertraline HCl) 50 mg, 100 mg scored tablets

BRIEF SUMMARY

ZOLOFT™ (sertraline HCl)

INDICATIONS AND USAGE: ZOLOFT (sertraline hydrochloride) is indicated for the treatment of depression.

CONTRAINDICATIONS: None known. **WARNINGS: In patients receiving another serotonin reuptake inhibitor drug in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued that drug and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Therefore, it is recommended that ZOLOFT (sertraline hydrochloride) not be used in combination with an MAOI, or within 14 days of discontinuing treatment with an MAOI. Similarly, at least 14 days should be allowed after stopping ZOLOFT before starting an MAOI.**

PRECAUTIONS ***General:*** **Activation of Mania/Hypomania** - During premarketing testing, hypomania or mania occurred in approximately 0.4% of ZOLOFT (sertraline hydrochloride) treated patients. Activation of mania/hypomania has also been reported in a small proportion of patients with Major Affective Disorder treated with other marketed antidepressants. **Weight Loss** - Significant weight loss may be an undesirable result of treatment with sertraline for some patients, but on average, patients in controlled trials had minimal, 1 to 2 pound weight loss, versus smaller changes on placebo. Only rarely have sertraline patients been discontinued for weight loss. **Seizure** - ZOLOFT has not been evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarket testing. Accordingly, like other antidepressants, ZOLOFT should be introduced with care in epileptic patients. **Suicide** - The possibility of a suicide attempt is inherent in depression and may persist until significant remission occurs. Close supervision of high risk patients should accompany initial drug therapy. Prescriptions for ZOLOFT should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. **Weak Uricosuric Effect** - ZOLOFT is associated with a mean decrease in serum uric acid of approximately 7%. The clinical significance of this weak uricosuric effect is unknown, and there have been no reports of acute renal failure with ZOLOFT. **Use in Patients with Concomitant Illness** - Clinical experience with ZOLOFT in patients with certain concomitant systemic illness is limited. Caution is advisable in using ZOLOFT in patients with diseases or conditions that could affect metabolism or hemodynamic responses. ZOLOFT has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from clinical studies during the product's premarket testing. However, the electrocardiograms of 774 patients who received ZOLOFT in double-blind trials were evaluated and the data indicate that ZOLOFT is not associated with the development of significant ECG abnormalities. ZOLOFT is extensively metabolized by the liver. The pharmacokinetics of ZOLOFT have not been studied in patients with significant hepatic dysfunction nor have patients with significant hepatic dysfunction been evaluated during treatment with ZOLOFT. Accordingly, ZOLOFT should be used with caution in such patients. Since ZOLOFT is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. However, until the pharmacokinetics of ZOLOFT have been studied in patients with renal impairment and until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with ZOLOFT, it should be used with caution in such patients. **Interference with Cognitive and Motor Performance** - In controlled studies, ZOLOFT did not cause sedation and did not interfere with psychomotor performance. ***Information for Patients:*** Physicians are advised to discuss the following issues with patients for whom they prescribe ZOLOFT: Patients should be told that although ZOLOFT has not been shown to impair the ability of normal subjects to perform tasks requiring complex motor and mental skills in laboratory experiments, drugs that act upon the central nervous system may affect some individuals adversely. Patients should be told that although ZOLOFT has not been shown in experiments with normal subjects to increase the mental and motor skill impairments caused by alcohol, the concomitant use of ZOLOFT and alcohol in depressed patients is not advised. Patients should be told that while no adverse interaction of ZOLOFT with over-the-counter (OTC) drug products is known to occur, the potential for interaction exists. Thus, the use of any OTC product should be initiated cautiously according to the directions of use given for the OTC product. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. Patients should be advised to notify their physician if they are breast-feeding an infant. ***Laboratory Tests:*** None. ***Drug Interactions:*** **Potential Effects of Coadministration of Drugs Highly Bound to Plasma Proteins** - Because sertraline is tightly bound to plasma protein, the administration of ZOLOFT (sertraline hydrochloride) to a patient taking another drug which is tightly bound to protein (e.g., warfarin, digitoxin) may cause a shift in plasma concentrations potentially resulting in an adverse effect. Conversely, adverse effects may result from displacement of protein-bound ZOLOFT by other tightly bound drugs. In a study comparing prothrombin time AUC (0-120 hr) following dosing with warfarin (0.75 mg/kg) before and after 21 days of dosing with either ZOLOFT (50-200 mg/day) or placebo, there was a mean increase in prothrombin time of 8% relative to baseline for ZOLOFT compared to a 1% decrease for placebo ($p<0.02$). The normalization of prothrombin time for the ZOLOFT group was delayed compared to the placebo group. The clinical significance of this change is unknown. Accordingly, prothrombin time should be carefully monitored when ZOLOFT therapy is initiated or stopped. **CNS Active Drugs** - In a study comparing the disposition of intravenously administered diazepam before and after 21 days of dosing with either ZOLOFT (50 to 200 mg/day escalating dose) or placebo, there was a 32% decrease relative to baseline in diazepam clearance for the ZOLOFT group compared to a 19% decrease relative to baseline for the placebo group ($p<0.03$). There was a 23% increase in T_{max} for desmethyldiazepam in the ZOLOFT group compared to a 20% decrease in the placebo group ($p<0.03$). The clinical significance of these changes is unknown. In a placebo-controlled trial in normal volunteers, the administration of two doses of ZOLOFT did not significantly alter steady-state lithium levels or the renal clearance of lithium. Nonetheless, at this time, it is recommended that plasma lithium levels be monitored following initiation of ZOLOFT therapy with appropriate adjustments to the lithium dose. The risk of using ZOLOFT in combination with other CNS active drugs has not been systematically evaluated. Consequently, caution is advised if the concomitant administration of ZOLOFT and such drugs is required. **Hypoglycemic Drugs** - In a placebo-controlled trial in normal volunteers, administration of ZOLOFT for 22 days (including 200 mg/day for the final 13 days) caused a statistically significant 16% decrease from baseline in the clearance of tolbutamide following an intravenous 1000 mg dose. ZOLOFT administration did not noticeably change either the plasma protein binding or the apparent volume of distribution of tolbutamide, suggesting that the decreased clearance was due to a change in the metabolism of the drug. The clinical significance of this decrease in tolbutamide clearance is unknown. **Atenolol** - ZOLOFT (100 mg) when administered to 10 healthy male subjects had no effect on the beta-adrenergic blocking ability of atenolol. **Microsomal Enzyme Induction** - Preclinical studies have shown ZOLOFT to induce hepatic microsomal enzymes. In clinical studies ZOLOFT was shown to induce hepatic enzymes minimally as determined by a small (5%) but statistically significant decrease in antipyrine half-life following administration of 200 mg/day for 21 days. This small change in antipyrine half-life reflects a clinically insignificant change in hepatic metabolism. **Electroconvulsive Therapy** - There are no clinical studies establishing the risks or benefits of the combined use of electroconvulsive therapy (ECT) and ZOLOFT. **Alcohol** - Although ZOLOFT did not potentiate the cognitive and psychomotor effects of alcohol in experiments with normal subjects, the concomitant use of ZOLOFT and alcohol in depressed patients is not recommended. ***Carcinogenesis, Mutagenesis, Impairment of Fertility:*** Lifetime carcinogenicity studies were carried out in CD-1 mice and Long-Evans rats at doses up to 40 mg/kg in mice (10 times on a mg/kg basis and the same on a mg/m² basis as the maximum recommended human dose) and at doses up to 40 mg/kg in rats (10 times on a mg/kg basis and 2 times on a mg/m² basis, the maximum recommended human dose). There was a dose-related increase in the incidence of liver adenomas in male mice receiving sertraline at 10-40 mg/kg. No increase was seen in female mice or in rats of either sex receiving the same treatments, nor was there an increase in hepatocellular carcinomas. Liver adenomas have a variable rate of spontaneous occurrence in the CD-1 mouse and are of unknown significance to humans. There was an increase in follicular adenomas of the thyroid in female rats receiving sertraline at 40 mg/kg; this was not accompanied by thyroid hyperplasia. While there was an increase in uterine adenocarcinomas in rats receiving sertraline at 10-40 mg/kg compared to placebo controls, this effect was not clearly drug related. Sertraline had no genotoxic effects, with or without metabolic activation, based on the following assays: bacterial mutation assay; mouse lymphoma mutation assay; and tests for cytogenetic aberrations *in vivo* in mouse bone marrow and *in vitro* in human lymphocytes. A decrease in fertility was seen in one of two rat studies at a dose of 80 mg/kg (20 times the maximum human dose on a mg/kg basis and 4 times on a mg/m² basis). ***Pregnancy—Pregnancy Category B:*** **Teratogenic Effects** - Reproduction studies have been performed in rats and rabbits at doses up to approximately 20 times and 10 times the maximum daily human mg/kg dose (4 to 4.5 times the mg/m² dose), respectively. There was no evidence of teratogenicity at any dose level. At doses approximately 2.5-10 times the maximum daily human mg/kg dose, sertraline was associated with delayed ossification in fetuses, probably secondary to effects on the dams. There are no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed. **Non-teratogenic Effects** - There was also decreased neonatal survival following maternal administration of sertraline at doses as low as approximately 5 times the maximum human mg/kg dose. The decrease in pup survival was shown to be most probably due to *in utero* exposure to sertraline. The clinical significance of these effects is unknown. **Labor and Delivery** - The effect of ZOLOFT on labor and delivery in humans is unknown. **Nursing Mothers** - It is not known whether, and if so in what amount, sertraline or its metabolites are excreted in human milk. Because many dru excreted in human milk, caution should be exercised when ZOLOFT is administered to a nursing woman. **Pediatric Use** - and effectiveness in children have not been established. **Geriatric Use** - Several hundred elderly patients have particip clinical studies with ZOLOFT. The pattern of adverse reactions in the elderly was similar to that in younger patients. **ADV REACTIONS** ***Commonly Observed:*** The most commonly observed adverse events associated with the use of ZOLOF traline hydrochloride) and not seen at an equivalent incidence among placebo-treated patients were: gastrointestinal comp including nausea, diarrhea/loose stools and dyspepsia; tremor; dizziness; insomnia; somnolence; increased sweating; dry and male sexual dysfunction (primarily ejaculatory delay). ***Associated with Discontinuation of Treatment:*** Fifte cent of 2710 subjects who received ZOLOFT in premarketing multiple dose clinical trials discontinued treatment due to an event. The more common events (reported by at least 1% of subjects) associated with discontinuation included agitation, nia, male sexual dysfunction (primarily ejaculatory delay), somnolence, dizziness, headache, tremor, anorexia, diarrhea stools, nausea, and fatigue. ***Incidence in Controlled Clinical Trials:*** The table that follows enumerates adverse eve occurred at a frequency of 1% or more among ZOLOFT patients who participated in controlled trials comparing titrated ZOLO placebo. Most patients received doses of 50 to 200 mg per day.

Treatment-Emergent Adverse Experience Incidence in Placebo-Controlled Clinical Trials*

Adverse Experience	ZOLOFT (N=861) (Percent of Patients Reporting)	Placebo (N=853) (Percent of Patients Repor
Autonomic Nervous System Disorders		
Mouth Dry	16.3	9.3
Sweating Increased	8.4	2.9
Cardiovascular		
Palpitations	3.5	1.6
Chest Pain	1.0	1.6
Central and Peripheral Nervous System Disorders		
Headache	20.3	19.0
Dizziness	11.7	6.7
Tremor	10.7	2.7
Paresthesia	2.0	1.8
Hypoesthesia	1.7	0.6
Twitching	1.4	0.1
Hypertonia	1.3	0.4
Disorders of Skin and Appendages		
Rash	2.1	1.5
Gastrointestinal Disorders		
Nausea	26.1	11.8
Diarrhea/Loose Stools	17.7	9.3
Constipation	8.4	6.3
Dyspepsia	6.0	2.8
Vomiting	3.8	1.8
Flatulence	3.3	2.5
Anorexia	2.8	1.6
Abdominal Pain	2.4	2.2
Appetite Increased	1.3	0.9
General		
Fatigue	10.6	8.1
Hot Flushes	2.2	0
Fever	1.6	0
Back Pain	1.5	0
Metabolic and Nutritional Disorders		
Thirst	1.4	0
Musculoskeletal System Disorders		
Myalgia	1.7	1
Psychiatric Disorders		
Insomnia	16.4	8
Sexual Dysfunction-Male (1)	15.5	2
Somnolence	13.4	5
Agitation	5.6	4
Nervousness	3.4	1
Anxiety	2.6	1
Yawning	1.9	0
Sexual Dysfunction-Female (2)	1.7	0
Concentration Impaired	1.3	0
Reproductive		
Menstrual Disorder (2)	1.0	0
Respiratory System Disorders		
Rhinitis	2.0	1
Pharyngitis	1.2	0
Special Senses		
Vision Abnormal	4.2	2
Tinnitus	1.4	1
Taste Perversion	1.2	0
Urinary System Disorders		
Micturition Frequency	2.0	1
Micturition Disorder	1.4	0

*Events reported by at least 1% of patients treated with ZOLOFT are included.
(1) - % based on male patients only: 271 ZOLOFT (primarily ejaculatory delay) and 271 placebo patients.
(2) - % based on female patients only: 590 ZOLOFT and 582 placebo patients.

Other Events Observed During the Premarketing Evaluation of ZOLOFT (sertraline hydrochloride): its premarketing assessment, multiple doses of ZOLOFT were administered to approximately 2700 subjects. Events are categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent events are those occurring on one or more occasions in at least 1/100 patients (only those not already listed in the tab results from placebo-controlled trials appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/ patients; rare events are those occurring in fewer than 1/1000 patients. Events of major clinical importance are also descri the PRECAUTIONS section. **Autonomic Nervous System Disorders**—*Infrequent:* flushing, mydriasis, increased cold clammy skin; *Rare:* pallor. **Cardiovascular**—*Infrequent:* postural dizziness, hypertension, hypotension, p hypotension, edema, dependent edema, periorbital edema, peripheral edema, peripheral ischemia, syncope, tachycardia; precordial chest pain, substernal chest pain, aggravated hypertension, myocardial infarction, varicose veins. **Central Peripheral Nervous System Disorders**—*Frequent:* confusion; *Infrequent:* ataxia, abnormal coordination, abn gait, hyperesthesia, hyperkinesia, hypokinesia, migraine, nystagmus, vertigo; *Rare:* local anesthesia, coma, convulsions, dy sia, dysphonia, hyporeflexia, hypotonia, ptosis. **Disorders of Skin and Appendages**—*Infrequent:* acne, alopecia, p erythematous rash, maculopapular rash, dry skin; *Rare:* bullous eruption, dermatitis, erythema multiforme, abnormal hair te hypertrichosis, photosensitivity reaction, follicular rash, skin discoloration, abnormal skin odor, urticaria. **Endocrine D ders**—*Rare:* exophthalmos, gynecomastia. **Gastrointestinal Disorders**—*Infrequent:* dysphagia, eructation; *Rare:* ticulitis, fecal incontinence, gastritis, gastroenteritis, glossitis, gum hyperplasia, hemorrhoids, hiccup, meleno, hemorrhagic ulcer, proctitis, stomatitis, ulcerative stomatitis, tenesmus, tongue edema, tongue ulceration. **General**—*Frequent:* ast *Infrequent:* malaise, generalized edema, rigors, weight decrease, weight increase; *Rare:* enlarged abdomen, halitosis, media, aphthous stomatitis. **Hematopoietic and Lymphatic**—*Infrequent:* lymphadenopathy, purpura; *Rare:* anemia, nor chamber eye hemorrhage. **Metabolic and Nutritional Disorders**—*Rare:* dehydration, hypercholesterolemia, glycemia. **Musculoskeletal System Disorders**—*Infrequent:* arthralgia, arthrosis, dystonia, muscle cramps, muscle ness; *Rare:* hernia. **Psychiatric Disorders**—*Infrequent:* abnormal dreams, aggressive reaction, amnesia, apathy, del depersonalization, depression, aggravated depression, emotional lability, euphoria, hallucination, neurosis, paranoid reactio cide ideation and attempt, teeth-grinding, abnormal thinking; *Rare:* hysteria, somnambulism, withdrawal syndrome. **Repro tive**—*Infrequent:* dysmenorrhea (2), intermenstrual bleeding (2); *Rare:* amenorrhea (2), balanoposthitis (1), breast e ment (2), female breast pain (2), leukorrhea (2), menorrhagia (2), atrophic vaginitis (2).

(1) - % based on male subjects only: 1005; (2) - % based on female subjects only: 1705.

Respiratory System Disorders—*Infrequent:* bronchospasm, coughing, dyspnea, epistaxis; *Rare:* brodypnea, hype lation, sinusitis, stridor. **Special Senses**—*Infrequent:* abnormal accommodation, conjunctivitis, diplopia, earache, eye xerophthalmia; *Rare:* abnormal lacrimation, photophobia, visual field defect. **Urinary System Disorders**—*Infre* dysuria, face edema, nocturia, polyuria, urinary incontinence; *Rare:* oliguria, renal pain, urinary retention. **Laboratory T** In man, asymptomatic elevations in serum transaminases (SGOT [or AST] and SGPT [or ALT]) have been reported infrequ (approximately 0.8%) in association with ZOLOFT administration. These hepatic enzyme elevations usually occurred with first 1 to 9 weeks of drug treatment and promptly diminished upon drug discontinuation. ZOLOFT therapy was associate small mean increases in total cholesterol (approximately 3%) and triglycerides (approximately 5%), and a small mean decre serum uric acid (approximately 7%) of no apparent clinical importance. **DRUG ABUSE AND DEPENDENCE** ***Contr Substance Class*** - ZOLOFT (sertraline hydrochloride) is not a controlled substance. ***Physical and Psychological De dence*** - ZOLOFT has not been systematically studied, in animals or humans, for its potential for abuse, tolerance, or ph dependence. However, the premarketing clinical experience with ZOLOFT did not reveal any tendency for a withdrawal syn or any drug-seeking behavior. As with any new CNS active drug, physicians should carefully evaluate patients for history o abuse and follow such patients closely, observing them for signs of ZOLOFT misuse or abuse (e.g., development of tolerance, mentation of dose, drug-seeking behavior). **OVERDOSAGE** ***Human Experience*** - There have been 3 cases of ZOLOF traline hydrochloride) overdosage (approximately 750-2,100 mg). No specific therapy was required for any of the 3 patier of whom recovered completely. ***Management of Overdoses*** - Establish and maintain an airway, insure adequate oxy tion and ventilation. Activated charcoal, which may be used with sorbitol, may be as or more effective than emesis or lavag should be considered in treating overdose. Cardiac and vital signs monitoring is recommended along with general symptomat supportive measures. There are no specific antidotes for ZOLOFT. Due to the large volume of distribution of ZOLOFT, forced diuresis, dialysis, hemoperfusion, and exchange transfusion are unlikely to be of benefit. In managing overdosage, consider the possibility of multiple drug involvement. The physician should consider contacting a poison control center on the treatment of any overdose.

Pfizer

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People

EWSMAKERS

ouston hematologist **Clarence Alfrey, D,** has been installed as the 1992 esident of the Harris County Medl Society.

hild magazine recently honored n Antonio orthopedic surgeon **bert Campbell, Jr, MD,** as one of the best pediatric specialists in the ation. Inventor of an expandable tanium rib implant for children ith severe birth defects, Dr Campll has begun US Food and Drug dministration trials for widespread e of the device.

dith Craven, MD, dean of the School Allied Health Sciences at The Unirsity of Texas Health Science Cenr at Houston, was appointed to the merican Medical Association's ommittee on Allied Health Educaon and Accreditation for 1992.

.C. Culbertson, Jr, MD, Dallas, reeived the 1991 Distinguished ward for Humanitarian Efforts uring the annual meeting of the merican Academy of Otolaryngolgy Head and Neck Surgery. Since 961, Dr Culbertson has traveled to orea, India, Japan, Kenya, Taiwan, nd Zaire to train local physicians nd provide medical care to the indient populations.

ease let *Texas Medicine* know about your nors and achievements.

iteria for inclusion in the Newsmakers secn are: TMA member; election or appointnt to an office of, or honors from, a naonal or state organization; or, space rmitting, recognition at the local level. ms for the Newsmakers section are pubhed at the discretion of the managing editor. bmit items for consideration, with photos if ssible, to People, Texas Medicine, *401 W th St, Austin, TX 78701.*

The mayor of Brownsville has issued a proclamation commending pediatrician **Rafael De la Cruz, MD;** obstetrician-gynecologist **Manuel Guajardo, MD;** dermatologist **Mario Henao, MD;** neurosurgeon **Jose Kuri, MD;** urologist **Jose Villalobos, MD;** cardiologist **Jim Simpson, MD;** and otolaryngologist **Chester Strunk, MD.** These physicians were recognized for their hours of volunteer work with patients at the community health center.

Cardiologist **George J. DiDonna, MD,** has begun his term as president of the El Paso County Medical Society. Other officers for 1992 include president-elect **Ronald Blumenfeld, MD; Marion S. Becker, MD,** vice president; secretary **Manuel L. Acosta, MD; Sergio Alvarez, MD,** treasurer; and **John N. Minuth, MD,** as assistant treasurer.

El Paso oncology specialist **Fred Ekery, MD,** has been chosen president-elect for the Texas Society of Medical Oncology. This group monitors medical and economic issues affecting cancer treatment in Texas.

Houston cardiologist **Rafael Espada, MD,** and nephrologist **Juan Olivero, MD,** each received the "Order of Rodolfo Robles," a medal presented by the president of Guatemala, Jorge Serrano. Dr Espada and Dr Olivero, both natives of Guatemala, were honored with Guatemala's highest medical education award for their contributions as medical conference participants and guest lecturers at The Methodist Hospital affiliate in Guatemala. They also have assisted Guatemalan medical students during their rotations at Baylor College of Medicine.

Alvin L. LeBlanc, MD, has been elected president of the Galveston County Medical Society. Dr LeBlanc is currently the associate dean for graduate medical education, assistant vice president for clinical affairs, and professor of obstetrics and gynecology at The University of Texas Medical Branch at Galveston. Installed as president-elect of the society is psychiatrist **Albert O. Singleton III, MD.**

Clifton F. Mountain, MD, professor of thoracic surgery at The University of Texas M.D. Anderson Cancer Center, is the first recipient of the Distinguished Achievement Award given by The International Association for the Study of Lung Cancer. In addition to launching the First World Conference on Lung Cancer, Dr Mountain developed an internationally accepted classification staging system for lung cancer.

Recipients of distinguished service awards at the Galveston County Medical Society annual installation banquet included **J.W. O'Bryant, MD; James C. Thompson, MD;** and **Carl J. Fuchs, MD.** These physicians have practiced medicine for 40 years or more.

Ronald P. Rapini, MD, associate professor of dermatology and pathology at The University of Texas Medical School at Houston, has been elected secretary-treasurer of the American Society of Dermopathology for 1993–1996.

Pedro A. Rubio, MD, Houston, was elected secretary of the 9th Joint Congress of the Asia-Pacific Federations of the International College of Surgeons.

Edgar B. Smith, MD, chairman and professor of the department of dermatology at The University of Texas Medical Branch at Galveston, has been chosen the 1992 Marion

Sulzberger International Lecturer of the American Academy of Dermatology. Dr Smith's lecture tour will include the Dominican Republic, Panama, Guatemala, Costa Rico, Mexico City, and Venezuela.

Courtney M. Townsend Jr, MD, Robertson-Roth Professor in General Surgery at The University of Texas Medical Branch at Galveston, is coeditor of *Surgical Oncology*, a new, international scientific journal. The journal was created to bridge the information gap between clinical cancer therapies and basic cancer research and to establish an international dialogue between physicians and cancer researchers.

Ophthalmologist **Barry W. Uhr, MD,** has been elected president of the Dallas County Medical Society.

OBITUARIES

Walter Philip Anthony, Jr, MD, 72; Fort Worth; Indiana University School of Medicine, 1943; died January 8, 1992.

Harold J. Bulgerin, MD, 65; Eastland; The University of Texas Medical Branch at Galveston, 1954; died January 9, 1992.

Benjamin Cooper, MD, 63; Houston; University of Witwatersrand, South Africa, 1953; died January 27, 1992.

J. Walker Davis, MD, 82; San Antonio; University of Tennessee Center for Health Science, 1937; reported deceased.

Harry L. Dein, MD, 79; San Antonio; Duke University School of Medicine, 1937; died July 17, 1991.

Richard T. Ellington, MD, 51; Arlington; The University of Texas Southwestern Medical School, 1966; died January 15, 1992.

Jarek P. Fisher, MD, 68; Anderson; Medical School, University of Zurich, 1955; died February 1, 1992.

Bernard Flanz, MD, 68; Houston; Baylor College of Medicine, 1948; died February 9, 1992.

George W. Frimpter, MD, 63; San Antonio; Cornell University Medical College, 1952; reported deceased.

Ann B. Harris, MD, 62; Missouri City; The University of Texas Medical Branch at Galveston, 1960; reported deceased.

Robert B. Homan, Jr, MD, 87; El Paso; The University of Texas Medical Branch at Galveston, 1930; died December 28, 1991.

Joseph M. Keith, MD, 77; Arlington; Baylor College of Medicine, 1941; died February 7, 1992.

William R. Lacewell, MD, 34; Longview; Baylor College of Medicine, 1983; reported deceased.

Harry Leaffer, MD, 80; Fort Worth; Tufts University, 1938; died February 9, 1992.

Ray W. Leavelle, MD, 46; Texarkana; University of Arkansas School of Medicine, 1970; died January 2, 1992.

Everett B. Lewis, MD, 81; Houston; University of Pennsylvania, 193; died January 23, 1992.

Howard J.H. Marshall, MD, 76; El Paso; The University of Texas Medical Branch at Galveston, 1942; died December 21, 1991.

Charles M. McBride, MD, 65; Houston; Dalhousie University, Nova Scotia, 1957; died January 17, 1992.

Ervin R. Smotherman, MD, 71; Arlington; The University of Texas Medical Branch at Galveston, 1943; reported deceased.

Paul C. Sullivan, 24; Houston; student at The University of Texas Medical School at Houston; died September 1, 1991.

Carmelo Vallejo, MD, 34; Brownsville; Universidad Central del Caribe, Escuela Medicina de Cayey, Puerto Rico, 1982; died November 18, 1991.

Sol B. Weil, Jr, MD, 86; Houston; Tulane University School of Medicine, 1930; died January 4, 1992.

Max R. Woodward, MD, 89; Sherman; The University of Texas Medical Branch at Galveston, 1925; died January 20, 1992.

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Office Phone (To be used only if added info is needed)
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Current Medical Specialty(ies)

Former Medical Specialty(ies) (for past 10 years)

List surgical procedures routinely performed

State(s) where currently licensed

States where formerly licensed (for past 10 years)

Amount of Professional Liability Insurance now carried
$

Is the doctor involved with delivery of babies? ☐ YES ☐ NO

Science and Education

Find the answers in science symposia at TMA Annual Session

"FIND THE ANSWERS IN San Antonio" is the theme of Texas Medical Association's 125th Annual Session on May 14–17. And if the chance to spend a few days amongst the fun, fiestas, and history of Old San Antonio isn't enough, the 1992 version of annual session offers physicians more than 40 scientific programs in every specialty during the 4 days.

Marilyn Baker, TMA director of medical information, said the association decided to begin focusing its annual session programs on primary care issues.

"There has been such a heavy emphasis on the socioeconomic issues facing physicians for most of this century, but their true interests are in practicing medicine," she said. "So in the last 4 or 5 years, the Councils on Public Health and Scientific Affairs have been really moving forward on programs focusing on science."

She said the councils are trying to strengthen TMA's role as an authority in science, public health, medical policy, and research.

"Several years ago, the Board of Trustees and the House of Delegates themselves sought to assure that the Texas Medical Association was the leading authority in setting medical policy and in guiding research in Texas," said Ms Baker.

Top researchers and practitioners from around the country will present some 255 credit hours of scientific programming. Among the program highlights are:

A new look at women's health issues

A "gender gap" in medical research has been identified as a growing problem that may affect diagnosis and treatment of women with cardiovascular disease, AIDS or HIV-infection, and depression. This symposium, scheduled from 9 am to 4 pm on Thursday, May 14, will inform physicians of epidemiological patterns of AIDS, HIV-infection, and cardiovascular disease among women and the manifestations of each in women as differing from those in men.

The program will be led by John W. Burnside, MD, Dallas, chairman of the TMA Council on Scientific Affairs, and Laurance N. Nickey, MD, El Paso, chairman of the TMA Council on Public Health. Guest speakers include Vivian W. Pinn, MD, Bethesda, Md; John P. Howe III, MD, San Antonio; John C. Jennings, MD, Winston-Salem, NC; Rebecca R. Clearman, MD, Houston; Jean A. Hamilton, MD, Dallas; Gabriel N. Hortobagyi, MD, Houston; Richard M. Grimes, PhD, Houston; and Joel S. Dunnington, MD, Houston.

Dr Pinn's program, "Research for Women's Health: The New Agenda," will discuss her role as director of the Office of Research on Women's Health at the NIH, which was established in 1990 to ensure the agency's research agenda adequately addresses important areas in women's healt that women are appropriately repr sented in biomedical research, ar that women are appropriately repr sented throughout the scientific ar research community.

Dr Howe will discuss cardiova cular disease in women; Dr Jennin will discuss estrogen therapy in th prevention of heart disease; D Clearman will discuss primary ca for women with physical disabilitie Dr Hamilton will discuss wome and depression; Dr Hortobagyi wi review recent advances in brea cancer; Dr Grimes will examine th growth of AIDS cases and HIV-in fection reported in women; and D Dunnington will discuss issues su rounding women and smoking.

The medical family

Practicing medicine can be a stressfu occupation, not only for the phys cian, but for his or her spouse an children as well. This symposium scheduled for 2:30–5 pm on Frida May 15, will examine the impact of medical career and help the physicia address stress arising from the com bination of family and professiona demands. It will examine sources o support as well as life-styles con ducive to healthy medical marriages.

The program will be led by Edga P. Nace, MD, Dallas, chairman o the TMA Committee on Physicia Health and Rehabilitation, an Margaret Smith, Corpus Christi chairman of the TMA Auxiliar Physician Health and Rehabilitatio Committee. The guest speaker wil be Jerry M. Lewis, MD, Dallas.

Dr Nace will discuss the role of th Committee on Physician Health an Rehabilitation, and Ms Smith, along with Betty Kepp of Corpus Christi will examine the Auxiliary's role i physician health and rehabilitation.

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

ıformation for this column comes from a variety of sources, including aca-ɜmic institutions, state and federal agencies, and private institutions. To ıbmit items of interest, write Texas Medicine, *Science and Education Edi-ır, 401 W 15th St, Austin, TX 78701.*

Finding may calm fears about AIDS in bone transplants

he University of Texas Health Science Center, San Antonio — Two re-searchers have discovered that a specific method of preparing bone for ansplantation kills the virus that causes AIDS. The discovery has eased ars that AIDS could be transmitted through bone implants. UTHSC-SA re-ɜarchers Mary Pat Moyer, PhD, and James Mellonig, DDS, will publish the ɜsults of their study in the *Journal of Periodontology* this year. The scien-sts studied methods of preserving bone tissue and discovered that bone eated with a virucidal process can be made free of the HIV virus. The re-ɜarchers note that HIV-infected bone is never used in transplantation, and ıe tests were designed to protect patients from the rare occasion — about 1 ı 1.67 million — that an infected donor's bone would slip through the creening process. There have been two instances of HIV transmission ırough bone implants, according to the American Association of Tissue anks. In both cases, bones had not been treated with a virucidal agent.

Study says eat the beef, savor the chocolate, but cut the butter

he University of Texas Southwestern Medical Center, Dallas — Studies done with middle-aged men have led researchers here to conclude that stearic cid, one of the primary fatty acids found in beef fat and cocoa butter, does not ignificantly raise low-density lipoprotein (LDL) cholesterol. Margo Denke, ID, associate professor of internal medicine, and Scott Grundy, PhD, director f the Center for Human Nutrition, looked at the effects of four common food ats — beef tallow, cocoa butter, butter fat, and olive oil — on the cholesterol evels of 10 test subjects. "We were testing the hypothesis that stearic acid loesn't have an effect on cholesterol," said Dr Denke. "We found that it loesn't." In the study, men ages 51 to 71 with moderately high to very high holesterol levels were fed a liquid diet containing 40% of the test fat for 3 veeks each. Butter fat raised the LDL cholesterol levels to 164 mg/dL; beef tal-ow raised the level to 156, cocoa butter to 148, and olive oil to only 140. A evel above 160 is considered a risk factor for heart disease.

M.D. Anderson to host regional breast cancer summit

he University of Texas M.D. Anderson Cancer Center, Houston — The National Cancer Institute has named M.D. Anderson Cancer Center to ıost one of eight regional summits on breast cancer this summer. "The Texas Leadership Summit: The Challenge of Breast Cancer" will be held June 1–2 at M.D. Anderson, the state's only NCI-designated Comprehensive Cancer Cen-ter. The event is sponsored by the NCI, the Susan G. Komen Breast Cancer Foundation in Dallas, and the Texas Federation of Business and Professional Women's Clubs, Inc. Organizers note that about 7,700 women were diag-nosed with breast cancer in Texas last year, and 2,300 died. Speakers at the summit will include physicians and allied health personnel from M.D. Ander-son, the University of California at San Francisco, the Komen Foundation, the National Black Leadership Initiative on Cancer, The Rose Breast Cancer Screening Center in Houston, and other programs from around the state.

Dr Lewis will discuss the current model of medical marriages that em-phasizes dysfunction, as well as data from a survey of 750 physicians, us-ing, among other instruments, a stan-dard marital satisfaction inventory. He will discuss his 30 years of re-search into the dynamics of healthy marriages and how the data apply to physicians and their spouses.

Environmental issues in primary care

The environment in which we live plays an increasing role in the health of Americans. This symposium, scheduled 2–5 pm on Thursday, May 14, is designed to increase practicing physicians' awareness and knowledge of environmental issues. (Also see this month's cover story, pp 38–44.)

The symposium will be led by Ralph D. Morris, MD, LaMarque, chairman of the TMA Committee on Environment, with guest speak-ers Bernard D. Goldstein, MD, Pis-cataway, NJ; Gary L. Smith, PhD, Austin; and Frank L. Mitchell, DO, Atlanta, Ga.

Dr Goldstein, who is director of the Environmental and Occupation-al Health Sciences Institute of the Robert Wood Johnson Medical School in New Jersey, will discuss the role of the primary care physi-cian in environmental medicine.

Dr Smith, of the Texas Depart-ment of Health, will present an up-date on the Texas Indoor Radon Survey. Exposure to elevated levels of indoor radon in residential struc-tures has been suggested to pose a public health risk due to an increase in incidence of lung cancer.

Dr Mitchell will discuss lead poi-soning in children, which is often not diagnosed until many other con-ditions have been eliminated. He will stress the need to screen all chil-dren under 6 years of age for lead poisoning.

An open forum to discuss the is-sues will close the program.

Medicine and the law

The number of governmental regula-tions a physician must be aware of and follow is growing on what ap-

pears to be an almost daily basis. This symposium, scheduled from 2–5 pm on Thursday, May 14, will give participants a better understanding of how federal and state governments have influenced and changed the way in which physicians practice medicine.

The symposium will be led by Randolph C. Zumer, MD, Kerrville, chairman of the TMA Committee on Professional Liability; Charles W. Bailey, MD, JD, Houston, and James M. Watts, MD, Fort Worth, cochairmen of the TMA Committee on Liaison with the State Bar of Texas. Guest speakers will include Martin J. Gaynes, JD, Washington, DC; Michael D. McKinney, MD, Centerville; and Joanne P. Hopkins, JD, Austin.

Mr Gaynes will discuss the federal impact on the practice of medicine, giving an overview of the ways in which federal law has changed the practice of medicine, and will examine how, as a practical matter, medicine can now be viewed as a federally regulated activity.

Dr Bailey will discuss areas of exposure in risk management, illustrating critical areas in the everyday practice of medicine that pose risk of medical liability.

Dr McKinney will discuss government and the practice of medicine from a practitioner/former legislator's viewpoint, and Ms Hopkins will examine selected state laws that have an impact on the practice of medicine, including the newly enacted illegal remuneration statute and the commercial bribery statute.

For more information on Annual Session, see the registration forms in the January and February issues of *Texas Medicine*, or call the TMA annual session and meeting management department at (800) 880-1300 or (512) 370-1451.

History of Medicine display to feature military medicine

IT IS DURING BATTLE THAT A DOCTOR often becomes the on healer in the midst of a brutal killing field.

To highlight the role physicians have played in wars, TMA's continuii "History of Medicine" exhibit is showing "From Sword to Scalpel: The Hi tory of Military Medicine in Texas, 1812–1945."

The exhibit contains the writings of physicians from the Texas Revolutic in 1836, The Civil War, Spanish-American War, World War I, and Wor War II. Medical manuals from the Civil War (written for the Confederac and World Wars I and II are on display, along with a Civil War surgery cas Many letters from prominent early physicians also are on display, includir a letter from J.H. Lyons introducing George Cupples, MD, to Sam Housto in 1853. Dr Cupples was the first president of TMA. The exhibit contains a extensive collection of other artifacts and memorabilia, according to TMA l brary director Susan Brock.

The exhibit will run through June 12 in the first floor display area of th TMA building at 401 W 15th Street in Austin. Exhibit hours are 8:15 am t 5:15 pm, Monday through Friday, and 9 am to 1 pm on Saturdays. It will b closed on some holidays. For more information, contact Ms Brock at (80(880-1300 or (512) 370-1540.

Research scientists get "framework" for NIH strategic plan

RESEARCH SCIENTISTS from Texas and across the nation gathered in San Antonio February 2–4 to begin plotting the future of biomedical research in America.

The symposium, "Today's Opportunities, Tomorrow's Health: The Future of Biomedical Research in America," cosponsored by the Southwest Foundation for Biomedical Research and the National Institutes of Health, was attended by more than 70 of the nation's top research scientists, including 19 members of the National Academy of Science and two Nobel laureates, to consider the research goals and opportunities for US research in the next century.

The primary focus of the conference was to have been the unveiling of a "strategic plan" for biomedical research, outlined by NIH Director Bernadine Healy, MD. But after changes that some sources say were made as late as a week before the conference began, the conferees instead heard a "framework" for a strategic plan presented to the conference.

The framework, according to Health and Human Services Secr tary Louis Sullivan, MD, was "a s rious process where we are lookir for input from the biomedical con munity at large, not just the NIH, to develop a plan to guide the age cy over the next 10 years.

Many of the assembled scientis were surprised at the apparer change in plan, since several ha been told by NIH colleagues to e pect an extensive plan that woul lay out the future direction of th agency. Instead, Dr Healy presente a 16-page document addressing fiv key areas:

- developing critical technologies;
- increasing research capacity;
- developing intellectual capital;
- stewardship of public resource and
- developing and maintaining pub lic trust.

Both Dr Healy and Dr Sulliva played down reports of a rift ove the plan.

Dr Sullivan told a news confer ence that "what has occurred up un til now has been the development o background information for th planning process. There is no quar rel between NIH and HHS."

Dr Healy added that those wh were disappointed with the length o

TMA continuing education conference planned June 18–20

THE TEXAS MEDICAL ASSOCIATION'S 1992 Continuing Medical Education Conference, "Pathways and Perspectives," will be held June 8–20 in Austin. Each year, the conference offers workshops and plenary ssions on a wide variety of issues of interest and educational value to hysicians involved with continuing medical education (CME) planning and nplementation.

The 1992 conference will focus on the issues of proposed FDA regulation f industry-supported CME activities and the outlook on mandatory CME n the 1993 Texas Legislature.

Featured speakers for this year's conference include State Rep David Cain D-Dallas), chairman of the Texas Sunset Advisory Commission; Francis Maitland, assistant secretary of the Accreditation Council for CME; David ichtenhauer, medical science and education liaison for the Upjohn Company; and Albert N. May, MD, chairman, accreditation committee of the Ohio tate Medical Society.

For more information, contact Carrie Laymon in the TMA medical eduation department at (800) 880-1300 or (512) 370-1446.

er paper may have been expecting o much.

The framework was to have been resented at four similar conferences round the country in February and Iarch, with NIH staff taking comients and input from all five meetigs and developing a final strategic lan to be released at an undisclosed ate later in the year.

Major topics of discussion at the onference included removing scince from the political arena, securg more research funding, and orinting programs toward more basic esearch.

Arthur Kornberg, PhD, a Stanford Jniversity professor of biochemistry, alled for caution on the part of govrnment when assessing the results of esearch with an eye towards future rants. Basic research could easily be verlooked, he said.

"It is the pursuit of curiosity that as been the most practical, cost-efective way to get a drug," he said. 'Basic research is the lifeline for ractical inventions in medicine."

Several Bush administration igures, including Dr Sullivan and Burton Lee, MD, the president's priate physician, used the conference o push the president's new healthare system proposals.

Also attending the conference were 51 top high school science students from all 50 states and the District of Columbia.

The symposium was staged to celebrate the 50th anniversary of the Southwest Foundation for Biomedical Research in San Antonio.

HealthFind program links physicians, rural communities

THE HEALTHFIND PROGRAM, coordinated by the Texas Center for Rural Health Initiatives, has announced its schedule for community training workshops and community-physician exchanges for 1992.

HealthFind works with both physicians interested in rural practices in Texas and communities who wish to attract a physician. Much of the program's focus is teaching communities how to market themselves to prospective physicians. The program teaches local community leaders how to analyze their medical needs and present the community in the best light to a prospective physician.

HealthFind community training workshops are scheduled April 27 in Amarillo, April 29 in Odessa, May 5 in Nacogdoches, May 7 in Corpus Christi, and June 24 in Austin (with TMA as host). This year's community-physician exchange is planned for September 26–27 in Fort Worth.

Officials with the HealthFind program say four physicians have been recruited through the program, and as of mid-February, four others are in various stages of contract negotiations.

For more information about the program, contact the Center for Rural Health Initiatives, PO Drawer 1708, Austin, TX 78767, or call (512) 479-8891.

TMA to cosponsor governor's conference on education

THE TEXAS MEDICAL Association is a cosponsor of The Governor's Conference on Science, Technology, and Math Education for the New Texas Schools, April 27–28, in Austin. The conference will focus on building business/education collaborations to improve schools in Texas. Participants from industry, education, and government will be provided with guidelines, skills, and resources for implementing partnerships in their communities.

As a conference cosponsor, TMA will help plan, organize, and implement the conference, according to Mary Rust, coordinator of scientific affairs. Physician leaders and staff will discuss TMA's various science education projects, including the Natural Science Ambassadors program, the "Milestones in Medicine" posters distributed statewide to science classes, and the annual program of awards recognizing outstanding science teachers in Texas.

According to John W. Burnside, MD, chairman of TMA's Council on Scientific Affairs, science education is a vital concern to physicians.

"Science education is the wellspring of all our future physicians, biomedical researchers, and people

engaged in biomedical enterprises," he said. "We are concerned in our medical schools about declining applications. It seems that science education is not receiving the attention it should, in Texas in particular and in the nation in general, for us to compete in the 21st century.

"Anything that we can do to enhance science education in the state of Texas is going to be in the best interests of all of us," said Dr Burnside.

The main organizer of the conference is the Texas Alliance for Science, Technology, and Mathematics Education. The alliance, which is sponsored by the Texas A&M University Development Foundation, works to improve student literacy and competency in science, technology, and mathematics education by fostering partnerships between schools and the private sector.

For more information on the conference, contact the alliance at (409) 845-0825, or Mary Rust at TMA, at (800) 880-1300 or (512) 370-1464. ★

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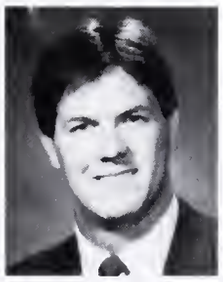

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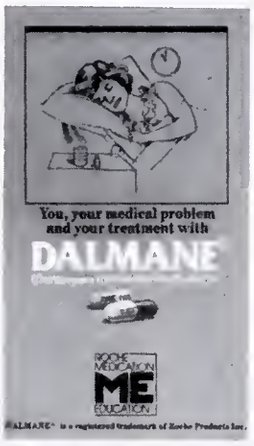

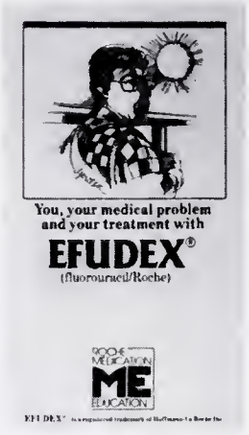

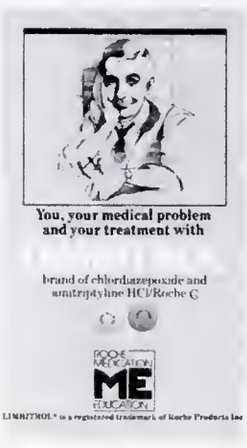

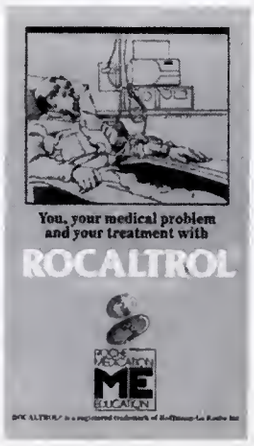

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Law

Exposure control plan deadline for OSHA regs May 5

ANOTHER DEADLINE IS looming on the horizon for physicians to comply with the Occupational Safety and Health Administration's (OSHA) regulations on bloodborne pathogens.

An exposure control plan must be in place by May 5. Initial information and training must be completed by June 4 and other provisions go into effect July 6.

The OSHA regulations are designed to reduce exposure to all bloodborne pathogens, including hepatitis B virus and the human immunodeficiency virus (HIV). Physician offices, hospitals, nursing homes, and other ambulatory health-care settings are subject to the regulations (*Texas Medicine*, February 1992, p 28).

To assist physicians in complying with the regulations, the Texas Medical Association has designed a workshop for physicians, office managers, or infection control managers. "OSHA and Infection Control" will be held April 21 in Tyler, April 22 in Austin, April 23 in San Antonio, April 24 in Dallas, April 28 in Fort Worth, April 29 in Amarillo, April 30 in Houston, and May 1 in Corpus Christi. The cost of the workshop plus a compliance plan is $99. For further information contact the TMA practice management department at (800) 880-1300 or (512) 370-1422.

Also, the American Medical Association has developed a comprehensive training program. The program, "For Your Protection: The OSHA Regulations on Bloodborne Pathogens," is available in kit format, which includes a 25-minute videotape, an administrator's guide, model exposure control, and training manuals. The kit is available for $195 for non-AMA members and $150 for AMA members, institutions, and hospitals. For information, contact the AMA at (800) 933-4AMT.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

Legal pitfalls of paying for referrals

Hugh M. Barton, JD
TMA Assistant General Counsel

The attention given to illegal remuneration issues has left many with the impression that the only potential problems in paying for referrals are in the federal and state "illegal remuneration" statutes. While these laws are the most often discussed, they are not the only ones available to combat alleged abuses.

Q: How do the antitrust laws relate to payment for referrals?

A: The Clayton Antitrust Act (1) prohibits exclusive dealing arrangements that tie sales and requirements contracts involving the sale of commodities where the effect may be to substantially lessen competition. It can be argued that, where persons or entities refer patients to each other and profit by referral, that relationship can lead to an "exclusive dealing arrangement" that unreasonably restrains trade when other referral sources are excluded.

For example, in *Advanced Health-Care Services, Inc, v Radford Community Hospital* (2), it was alleged that the defendant hospital had a business relationship with a defendant durable medical equipment (DME) company in which t hospital received 65% of all the re enues generated by the DME comp ny's rentals to discharged patient Further, hospital discharge personn were paid $40 for each patient wh ordered equipment from the DM company and were threatened wi dismissal if they did not steer p tients to the DME company.

A competing DME company fil suit under the Clayton Act, allegi that this business relationship cons tuted an exclusive dealing arrang ment that substantially lessene competition and enabled the defe dant DME company to achiev monopoly power in the DME ma ket. The 4th Circuit Court of A peals held that such allegations we sufficient to survive the hospital motion to dismiss.

A similar holding by the 11t Circuit Court of Appeals occurred i *Key Enterprises of Delaware, Inc, Venice Hospital* (3), another case i volving DME suppliers. There th court addressed the issue of antitru injury as follows:

> ". . . the channeling of patie choice is sufficient to show inju to consumers. The antitrust law do not require the consumer t suffer some form of monetar damage before a defendant's a titrust conduct is actionable."

The court added that "because the regulated nature of Medica and Medicaid reimbursements, th primary means of competition quality and service. The defendan here have knowingly and purposel set in place a scheme which insulat the unknowing patient from learnin of these nuances."

Thus, a business relationship i which payment for referrals occu

ıy pose the risk of legal liability t only under the more familiar "il-;al remuneration" statutes, but der the federal antitrust laws as ll. Because an excluded competi- has standing to sue in such in- nces, as in the cited cases, a basic owledge and awareness of an- rust laws will help physicians oid conduct that violates the law.

Can a payment for referrals arrange- nt be prosecuted criminally in Texas tutes other than the recent "illegal re- neration" law?

The Texas "commercial bribery" ıtute is another law available to osecute illegal remuneration cases state court. In fact, the comments at accompany the text of the ıtute in the Texas Penal Code ecify that it is "aimed principally kickbacks." This offense carries ony penalties.

The statute provides that a iduciary" commits an offense if, ithout the consent of the eneficiary," he knowingly solicits, cepts, or agrees to accept any nefit from another person with an reement or understanding that the nefit will influence the conduct of e fiduciary influence in relation to e affairs of his beneficiary. Benefit" refers to anything reason- ly regarded as economic gain or lvantage.)

The statute is important in evalu- ing business arrangements with re- rral sources because, in the context of a physician-patient relationship, the physician is considered to be a fiduciary. The offense does not require that the beneficiary be harmed by the fiduciary's actions or conduct.

Thus, where there is an express or implied "agreement or understanding" between partners in a medical facility that operates from patient referrals by the partners (such as an imaging center), in which the distribution of partnership benefits is intended to influence physician partners to refer to the facility, the distribution of benefits could constitute commercial bribery.

Physicians who invest in joint ventures with their hospitals should be aware of possible tax complications.

In other words, even though there may be no contractual obligation to refer patients, the mere fact that a physician partner is entitled to share in partnership distributions on the basis of referrals of patients could be deemed an "understanding" between the parties to refer patients.

There are no known cases in which this statute has been used against physicians. However, it has been used against attorneys, and in that context it has been held that one lawyer's offering another lawyer an economic benefit in consideration for the lawyer's breach of fiduciary duty owed to a client is not a legitimate negotiation tactic; it is bribery (4).

However, the law provides that no offense is committed if the consent of the beneficiary is obtained. Therefore, if the physician partners obtain the written consent of each patient that the physician refers to the entity, the risk of criminal exposure posed by the commercial bribery statute is arguably eliminated.

Q: What are the tax implications of paying for referrals?

A: Many business arrangements that raise illegal remuneration issues involve hospitals, and potential tax consequences exist for hospitals in this area, particularly for those with nonprofit tax status. The Internal Revenue Service has, in the past, approved specific hospital-physician joint ventures involving a sale of part of the hospital's net revenue stream. Recently, however, the IRS' general counsel issued a memorandum changing that (5).

This memorandum addresses whether a hospital that is tax exempt under Section 501(c)(3) of the Internal Revenue Code jeopardizes that exempt status by forming a joint venture with members of its medical staff and selling to the joint venture the gross or net revenue of an existing hospital department or service for a defined period of time. The memorandum concludes that a hospital entering into such a transaction jeopardizes its tax exemption.

The IRS balanced the private benefits of the arrangement with the public benefits achieved and concluded that the public benefit that the hospital expected to result from the arrangement — enhanced hospital financial health or greater efficiency through improved utilization — had only the "most tenuous relationship" to the hospital's charitable purposes of promoting the health of the community. "Obtaining referrals or avoiding new competition may improve the competitive position of an individual hospital," states the IRS, "but that is not nec-

gal articles in Texas Medicine *are intend- to help physicians understand the law by oviding legal information on selected top- . These articles are published with the un- rstanding that TMA is not engaged in pro- ding legal advice. When dealing with ecific legal matters, readers should seek as- tance from their attorneys.*

essarily the same as benefitting its community."

The hospitals had argued that engaging in the joint ventures was necessary if they were to operate efficiently, compete, or possibly even survive. The IRS disagreed, stating, "The [Internal Revenue] Code commands otherwise. The ends here — preserving or expanding market share — cannot justify use of means that violate its restrictions."

In closing, the IRS issued a thinly veiled threat: "There may be one or more tax exempt hospitals that have chosen to enter into the sale of net revenue streams arrangements without benefit of an advance ruling. Depending on the facts, revocation of the hospital's exemption might well be appropriate in such cases."

As for tax-paying hospitals, the memorandum pointed out that existing tax law denies business expense deductions for kickback for Medicare or Medicaid services.

Therefore, physicians who invest in joint ventures with their hospitals should be aware that, under the right set of facts, there may be tax complications.

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Minimize liability with risk management

David S. Starr, MD, JD
Bankston, Wright & Greenhill
Austin, Texas

RISK MANAGEMENT PROGRAMS are designed to minimize legal liability by helping physicians to maintain a high standard of practice, to encourage positive patient attitudes toward the physician, and to avoid high risk situations.

Most risk management programs are hospital-based and are centered about activities occurring in institutions. However, many of the same principles can be applied to office practice.

Physicians in many states have experienced a measure of relief from medical liability litigation by the passage of tort reform packages subsequently upheld by the state supreme courts (1). In the 1980s, Texas was one of the most favorable states for plaintiff's lawyers in medical litigation, probably due to a prior disproportionate influence of plaintiff's lawyers in the legislature and supreme court (2). More recently, some defense lawyers have noticed a more restrained attitude in jurors on medical liability cases. Few legislative changes in substantive law have been upheld in Texas, although Texas Supreme Court decisions since the 1988 and 1990 election cycles provide encouragement that the current court will be less eager to find reasonable legislative tort reforms unconstitutional (3). In any event, the need for effective loss control and risk management practices is likely to be with us for many years to come.

Recognizing "high risk" patients

Certain types of patients and certain medical conditions or procedur should be approached with circur spection because of the high pote tial for litigation.

A 1973 federal report on medic malpractice noted several facto identifying a high risk group of p tients for malpractice claims. Amor other things, previous experien and familiarity with the legal sy tem, especially as a plaintiff, was leading correlate (4).

Since 1973, the group of patien willing to enter the "lawsuit lottery probably has broadened conside ably, with previous experience of li igation still a common factor. Th same report noted that patient fru tration, hostility, and anger were significant initiating cause of lav suits (5). The physician should b alert to the patient with an inextr cable mixture of unresolved perso ality conflicts, especially involvir inappropriate anger or a history alcohol or drug abuse. Attempts t be a "white knight" to such a pa tient may well result in being calle as an expert to testify against th previous physicians or being name along with them in the "all-inclu sive" lawsuit.

Similarly, certain office procedur place the physician at special risl For example, procedures performe under light general anesthetic or loc anesthesia with sedation in the offic are high risk situations for litigatio This is partly because experienc shows that anesthesia experts, usua ly full-time hospital anesthesiologist are often critical of the office situa tion for this type of anesthesia.

Every specialty has certain proc dures in which poor outcomes co sistently lead to litigation. Two e amples are thoracic outlet syndrom in thoracic surgery and neonatal i jury in high risk obstetrics. Phys

ns should identify such areas in ir own practices and should take cial precautions, have complete cumentation, and routinely seek nsultation with colleagues on se patients.

ice records

intiff's lawyers have often man- ed to convince juries that events t charted in the patient's hospital art did not occur.

Over recent years, the need to keep re complete records has become parent to hospital risk managers, d hospital records usually allow the fense lawyer to prepare an effective fense. Physicians should use their spital's charting system to set the ndard for their own office records. e physician's findings, diagnosis, d recommendations should be arly set out, since "he never told " is the usual plaintiff's claim. ndwritten notes are adequate, but ould at least be legible to the doc- r. If the physician cannot write oid, accurate, or legible notes, he or e should consider preprinted forms th checklists. Information can also recorded on a portable cassette corder and the notes transcribed d filed. Tests ordered should be not- and the results filed after review by e physician, with a notation by the aff or physician as to if and when e patient was notified.

Office charts can often be stream- ned with custom diagrams and xes to be checked for clinical find- gs and other items, such as "book- given to pt." The small extra ex- nse is easily justified in terms of me saved, when compared to the gravation of even one lawsuit.

Most important, the physician ould never go back and alter or add the original chart. Any alterations be made, such as striking out entries made in the wrong chart, should be done so that it is quite clear that no deceit was intended. Changes should be dated and initialized.

Clandestinely altering the chart is legal dynamite and has lost several otherwise winnable cases.

Patient communication

Experience shows that many adverse events could have been prevented if the physician had been aware of changes in the patient's condition arising after the patient's visit.

A system for patient callbacks can keep the physician or his or her assistant aware of problems as they develop. Such calls should be entered in the daily log, along with action taken or advice given. Here good office practice and risk management dovetail, since follow-up calls detect new problems, avoid complications, and often result in further patient visits and referrals. On the other hand, notifying patients of the results of Pap smears and other routine tests by mail can place the physician in a difficult position if the patient does not get the test results and blames the physician for failure to notify.

The "new patient" information sheet is a valuable means of communication. The doctor can use this to gather information about prior physicians, past medical history, medications, personal habits, and payment data — all useful information when assessing the "whole patient." During the initial interview, the patient may disclose hostility towards previous physicians, drug or alcohol abuse, or unresolved problems with anger and aggression. Looking at the whole picture, the physician may be better able to address the patient's medical needs or to conclude that the patient would be better served by another physician. If in doubt, the physician may ask the patient for permission to call the other doctors and discuss the case with them. The patient's response to this request may reveal additional helpful information.

Clandestinely altering the chart is legal dynamite and has lost several otherwise winnable cases.

The initial patient visit is a good opportunity to set the rules for the physician-patient relationship. Such items as after-hours calls, prescription refills, charges, and missed appointments can be clarified by printed information sheets.

Patient education and informed consent

The two issues of practice promotion and risk management also fuse in the area of informed consent.

Patients appreciate modern teaching aids, including videotapes, plastic models, booklets, movies, and magazine articles, as well as more formal American Medical Association booklets on specific conditions or medications. If such items are routinely used, they become evidence of "informed consent" for the physician and can be introduced as courtroom evidence. The patient who claims he or she was never warned of the risks of some medication or condition loses credibility if booklets with that information were routinely given to similar patients, and even more so if a notation, even a checkmark, has been made in the patient's chart.

In preparing patients for the "list

A procedures," promulgated by the Texas Medical Disclosure Panel, Texas law requires disclosure of specific risks and complications for the doctor to enjoy the presumption that informed consent was given (6), but generally the physician must disclose "what a reasonable person would want to know" (7). This has been interpreted to include discussion of alternatives and consequences of lack of treatment as well as the risks and benefits of the recommended treatment (8). Despite the realities of clinical practice, the law operates on the basis of this theoretical model of "patient autonomy," and the physician's notes should reflect this. Notations such as "risks and benefits explained, questions answered, patient agrees" usually suffice, except in special high risk situations.

Risk Management Practices

- Be aware that certain office procedures place you at special risk.
- Use a hospital charting system in your own office.
- Handwritten notes should be legible. If not, use preprinted forms or a hand-held recorder.
- Note tests ordered and file after review. Include a notation if the patient was notified of the tests.
- Develop a callback system.
- Use an information sheet to assess the complete patient.
- Distribute teaching aids (booklets, plastic models, magazine articles, and videotapes) to your patients.
- Explain specific risks and complications that can result from certain procedures.
- Good practice management develops rapport with patients.

Developing customer relations

Sometimes it is helpful to view your practice from the perspective of the patient. The average person is not interested in litigation, but is interested in service, positive attitude, and efficiency.

The waiting room should be as attractive as a limited budget allows; the staff should be upbeat and attentive and perhaps slightly extroverted; patient appointments should be timely; and simple telephone queries should be answered with simple, standardized answers. More complex problems, and possibly even prescription refills, should trigger an office visit. Surveys show that a major cause of patient discontent is excessive waiting, especially beyond 20 minutes. To improve efficiency, the patient's blood pressure, weight, and temperature can be recorded by a non-MD assistant prior to an examination by the physician.

Although not usually considered part of risk management, good practice management enhances patient satisfaction and creates a favorable aura around the doctor. Doctors who consistently run an efficient practice tend to build up a reservoir of goodwill that can help them through some bad spots with an individual patient. There have been some instances when every doctor in the chart was named as a defendant, except the family practitioner, on the basis of many years of efficient health care and resulting goodwill.

Reducing risk of lawsuit

Office practices vary widely, but it appears that more risk is being transferred out of the hospitals to the doc tor's office. Good practice manage ment and effective risk managemen often overlap, but in some areas identification of "high risk" patient requires extra care, extra documenta tion, and often consultation.

The use of more efficient recor systems, patient handouts, notation as to informed consent, and overal practice management appear to sig nificantly reduce the individual prac titioner's risk of a lawsuit, and en hance the chance of success when o if one is filed.

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Lead. Radon. Pesticides.

Water contamination. Toxic waste.

Air pollution. Raw sewage.

Environmental Encounters

It's all out there waiting for your patients.

What should you be doing

to help them deal with environmental

encounters of the dangerous kind?

BY LAURA J. ALBRECHT, ASSOCIATE EDITOR

Awareness on the agenda

Bernard Goldstein, MD, firmly believes it is up to physicians to be aware of environmental dangers that might be linked to their patients' illnesses.

"A good physician has to know what the risks are in the community where he or she practices," says Dr Goldstein. "Patients are taking up so many bizarre activities these days. You have to consider their occupational history along with their hobbies."

Echoing concerns for health problems relating to the environment is Ralph D. Morris, MD, chairman of the TMA Committee on Environment.

"Most of us were taught in an era when environmental concerns were not thought to be as important as they are today," says Dr Morris, who oversees the Galveston City Health District. "There is a tendency to underemphasize the role of the environment when evaluating a patient. What environment do they live in and work in and how does it affect them?"

As professor and chairman of the department of environmental and community medicine at the University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, and also director of the Environmental and Occupational Health Sciences Institute, Dr Goldstein knows what is out there on a day-to-day basis that can endanger patients. (Dr Goldstein will present information on the role of the primary care physician in environmental medicine at the 125th Annual Session of the Texas Medical Association in May [see box, p 40].)

"There has been a concern among agencies dealing with environmental issues that physicians are simply not knowledgeable about what is harmful to their patients," says Dr Goldstein, an internist who became involved in issues surrounding air pollution in the 1960s. He says concerns develop when there are environment-related problems in the community of which physicians are not aware.

Trouble also brews when a physician makes a statement about an issue plaguing a community and later discovers a lack of knowledge might mean the problem has a greater or lesser impact on the community.

"Physicians are and should be authorities on issues dealing with public health," says Dr Goldstein. A too-quick diagnosis or assumption can result in creating a problem that never existed in the first place. "But this can be corrected with information and knowledge."

Dr Goldstein recalls one incident involving lead poisoning that shows how knowing what patients are exposed to at home and work can lead to finding solutions to mystery ailments.

> "A good physician has to know what the risks are in the community where he or she practices."

A young man decided to earn some additional money by renovating old homes in his spare time and then selling them. He became ill while undertaking these projects. He went to his physician who found nothing physically wrong with him, decided he must be having problems with his girlfriend, and sent him to a psychiatrist. The patient was under psychiatric care for a while, but his illness continued. The patient's father, while on vacation in Florida, had a chance meeting with the family physician who had treated the young man since childhood. The retired doctor asked about the family and learned of the young man's illness. Knowing the young man was involved in restoring houses, the doctor suggested it might be lead poisoning.

"It took a retired, family doc on the beach in Florida to make a correct diagnosis," says Dr Goldstein, pointing out that the diagnosis was possible simply because the physician knew the patient's activities.

Another environmental hazard confronting physicians is pesticide poisoning, which can strike migrant farm workers particularly hard. There is ample opportunity for exposure to pesticides, particularly when a mother takes her children into the fields.

"One of the worst situations is when a mother, with a baby on her back, takes the child into the field," says Dr Goldstein. "Not only is the mother getting a direct dose, but the baby might also get a dose through crop spraying and then through nursing.

"Then the child reaches toddler stage, begins to play in the pesticide-contaminated soil, and there is more exposure," says Dr Goldstein.

To assist physicians in gaining a better understanding of the environment, Dr Goldstein would like to see medical schools become more involved in environmental and occupational medicine education. He also advocates an increase in continuing education on these topics for practicing physicians.

Dr Morris agrees that physicians need more sources of information on environmental health concerns.

"Getting the knowledge out to physicians, who in turn can share this with their patients, is extremely important," says Dr Morris. "Research has shown that the public looks to physicians as reliable sources of information, particularly in the area of the environment. That is why we have an obligation to really educate ourselves. There are a lot of people out there who have their own agendas that over- or underemphasize environmental issues. There's no question there can be a balance between environmental concerns and economic development. It is critical

for a practicing physician to have a good scientific base to determine what we know and don't know."

With assistance from the TMA environmental committee, Dr Morris hopes the issues will be seen from the scientific point of view so that the physician can work with his patients and within his community on a more knowledgeable level. "You can't watch a news program or pick up a newspaper without a report on the environment," he says. "The issue isn't going away, and, in fact, it is going to get worse.

"Physicians must be aware of the physical environment and side effects it has on their patients' health and, for that matter, their own health and their family's health," says Dr Morris. "Our physical environment is changing, along with our knowledge. How this affects our health is also being developed. Air and water pollution, lead poisoning, and pesticide exposure are all good examples of that. Lead exposure, for example, we have known for years is hazardous to the unborn child and children. But, we have recently developed a new knowledge that levels we thought were safe are actually detrimental."

Lead poisoning: it's preventable

Tagged a "silent" disease by the Centers For Disease Control, lead poisoning in children presents a unique set of obstacles.

It is important to realize lead poisoning is not just a disease of lower socioeconomic populations. It can strike all classes and is being seen more frequently in middle-class patients.

"Lead poisoning is not a respecter of socioeconomic levels," says Frank Mitchell, DO, chief medical officer for the Agency for Toxic Substances and Disease Registry at the US Public Health Service in Atlanta. "Doctors can get into a mind-set that their patients are middle-class and, therefore, they don't have to be concerned about lead poisoning."

Incidences of lead poisoning are certainly not staying within the boundaries of socioeconomic levels. "We are seeing cases develop among younger families who are moving into older neighborhoods and renovating houses," says Dr Mitchell. Another interesting example is women who leave their jobs during the 8th or 9th month of pregnancy and renovate the baby's nursery. They start sanding (to remove lead paint) and end up with exposure to lead.

"By definition, any house built prior to 1960 has lead paint on it," says Dr Mitchell. Paint can peel from the house and become embedded in the soil. It's when children play in this area that a problem develops.

In addition to lead paint, two other potential sources of lead warrant consideration: some imported and homemade pottery and water pipes can contain dangerous levels of lead.

"The lead is not coming from just one source," says Dr Mitchell. "There is a little in the soil and dust, a little bit inside the house, a little bit in the air, maybe a little bit in the water, and then some in the food. Before you know it you have a lot; it is a cumulative kind of situation.

"It is the awareness factor that is difficult to get across to doctors, because in lead poisoning we are dealing with a condition that is totally preventable," says Dr Mitchell, and "totally treatable."

Radon: what and where is it?

You can't taste it, see it, or smell it. Yet, it ranks behind smoking as the second leading cause of lung cancer.

"Radon has been around for a long time," says Gary L. Smith, PhD. "But only recently has it come to be of concern in houses."

A statewide screening of radon in Texas revealed about 4% of the houses with concentrations above the Environmental Protection Agency action level (4pCi/1). "We found, in general, that the state as a whole has a low probability for radon problems," says Dr Smith, a physicist with the Texas Department of

Environmental Issues Program slated *for* Annual Session

THE RELATIONSHIP of th environment and medicin will be addressed during th Environmental Issues in Pri mary Care program at th 125th Annual Session of th Texas Medical Association i San Antonio.

The program, schedule Thursday, May 14, from 2–5 pm, will feature discussions o lead poisoning in children radon, and an overview of th role of the primary care physi cian in environmental medicine.

Speakers will be Bernar Goldstein, MD, professor an chairman of the departmen of environmental and commu nity medicine and director o the Environmental and Occu pational Health Science Institute at the University o Medicine and Dentistry o New Jersey, Robert Woo Johnson Medical School Gary L. Smith, PhD, Texa Department of Health environmental assessmen branch; Frank Mitchell, DO FACPM, chief medical officer agency for toxic substance and disease registry at the US Public Health Service; an Ralph D. Morris, MD, chairman of the TMA Committee on Environment.

There will also be environmental exhibits and materials available to physicians during the annual session.

For further information about annual session, see page 24 or contact the TMA department of annual session and meeting management, 401 W 15th St, Austin, TX 78701, (800) 370-1300 or (512) 370-1450/1451.

ealth. "We did find a couple of eas, the Panhandle and Big Bend, at had an increased incidence for gher concentrations of radon."

A natural breakdown of uranin found in certain rock types reilts in radon. "Geology is the umber one factor for assessing idon potential in an area," says r Smith.

The fact that people started ooking for radon and the conruction of energy-efficient homes rought attention to the radioacve gas. "Anytime you build a ouse that is energy efficient, you end to trap gases — all kinds of ases," says Dr Smith. "Very often house is built to keep heat in round walls and ceilings, but may ave conduits for soil gas to come through the floor. Those kinds of ouses can accumulate radon gas."

High levels of radon in homes ere first discovered in the early 980s in Colorado and Utah. This eveloped as a result of materials om uranium mines being inadertently incorporated into housng construction. With curiosity bout radon interest on the inrease, another incident occurred t a nuclear power plant in Pennylvania. An employee at the plant et off a personnel monitoring deice designed to detect levels of raioactivity. Since fuel rods for the lant had not been loaded, this uzzled plant officials. "His house as so grossly contaminated with adon that his clothing was raioactive enough to set off sensive alarms," says Dr Smith.

"So far, the only ill-health outome associated with radon is an ncreased risk of lung cancer," ays Dr Smith. With cooperation rom the media, Dr Smith hopes to lert physicians who practice in reas where radon potential is oncentrated.

Dr Goldstein believes doctors an take action to alert patients bout the dangers of radon. "If a hysician practices in an area that as a high level of radon, the only way to convince people to check heir homes for radon is to have your own home checked. It's real easy to do and the impact can be enormous."

On the other hand, physicians can help calm patients' fears about radon when those fears are based on misconceptions about the existence of radon in certain areas of the state.

LEAD

Lead poisoning is one of the most common pediatric health problems in the United States, according to the Centers for Disease Control. And it is a problem that physicians can take steps to prevent in their young patients.

WHERE IS IT FOUND?

- Lead can be found in a variety of sources, including lead-based paint, soil, dust, drinking water, parental occupations and hobbies, air, food, and "traditional" medicines.
- The most widespread and dangerous high-dose source of lead exposure for children is lead-based paint. About 74% of homes built before 1980 contain lead-based paint.
- Lead can be ingested through contaminated dust and soil.
- Drinking water can become contaminated with lead within the distribution system.
- Parents who take home lead on their clothing risk exposing their children. Hobbies that might increase exposure include furniture refinishing, making stained glass, doing home repairs and remodeling, and pottery making.
- Airborne lead (from gasoline) has resulted in soil and dust contamination.
- Food can be contaminated with lead through improperly fired ceramic-ware, leaded crystal, and lead-soldered cans.
- Other sources of lead poisoning include cosmetics, ammunition, fishing weights, toy soldiers, and burning lead-painted wood.

WHAT IS THE DANGER?

- Lead is a poison that affects virtually every system in the body.
- The developing brain and nervous system of fetuses and young children are particularly susceptible to poisoning.
- Levels as low as 10 μg/dL are associated with adverse effects.
- Severe levels greater than or equal to 80 μg/dL can cause coma, convulsions, and even death in children. Central nervous system, kidney, and hematopoietic system suffer at lower levels.
- Children are at higher risk because they have more hand-to-mouth activity and absorb more lead than adults.

WHAT CAN PHYSICIANS DO?

- Educate parents about causes of childhood lead poisoning.
- Screen young patients and interpret blood lead test results.
- Make sure that poisoned children receive appropriate medical, environmental, and social service follow-up. This can be accomplished by working with groups in both the public and private sectors.
- Become involved in lead-poisoning prevention activities by working with public health officials.

Sources: Centers for Disease Control statement: Preventing Lead Poisoning in Young Children.

Research: the missing link?

A real public health mystery. That is what Claudia S. Miller, MD, calls multiple chemical sensitivity (MCS).

MCS has been reported by individuals following a major chemical

RADON

While radon is not as prevalent a threat in Texas as in other states, many patients are still frightened by this cancer-causing source. By knowing the facts about radon, physicians can help protect their patients.

WHAT IS IT?

- A naturally occurring radioactive gas that comes from the breakdown of uranium.
- High concentrations can be found in soils and rocks containing uranium, granite, shale, phosphate, and pitchblende.
- Soils contaminated with certain types of industrial wastes (byproducts from uranium or phosphate mining) can contain radon.

WHAT IS THE DANGER?

- It is the second leading cause of lung cancer.
- Risk increases based on level of radon and length of exposure.
- Gas seeps into homes through cracks and other openings in the foundation.
- It can also be released from well water while washing clothes, showering, and other household activities involving water.
- Elevated levels of radon are usually found in basements and ground floors in contact with the soil. Design, construction, and ventilation can draw radon into the house.
- Smokers face a greater risk because of the interaction of tobacco and radon. The sensitivity of children's lungs place them at a higher risk. The risk of lung cancer may be three times greater for children and adolescents than for adults.
- Eight million homes throughout the US may have elevated levels of radon according to the EPA.

WHAT CAN PHYSICIANS DO?

- Learn about the geological formations in the area where you practice. Have high levels of radon been recorded? Even in areas with radon, most houses will probably not have highly elevated levels.
- Alert patients who may be exposure candidates about radon. Homes can be tested to determine radon levels. Test kits are available for long-term and short-term testing. Short-term testing, which lasts a few days or several months, can determine if a potential problem exists. More accurate are long-term tests that take up to a year. The tests can be administered by the homeowner or a private firm can do the testing. The problem of radon can be corrected.
- Information is available from the Texas Department of Health (TDH) and Environmental Protection Agency (EPA). Call (512) 834-6688 for information from TDH. The EPA Hotline is (800) SOS-RADON.

Sources: American Medical Association, Texas Department of Health, and Environmental Protection Agency.

exposure, eg, to a solvent spill, pesticide, or tight building; subsequently these patients develop a host of symptoms that they attribute to many common chemicals exposures, such as smoke, perfume, or diesel exhaust. "The exposure triggers very disabling symptoms (such as mood and memory difficulties), and the individual experiences sensitivities he didn't have prior to the exposure episode," says Dr Miller, clinical assistant professor in allergy and immunology at The University of Texas Health Science Center at San Antonio and member of the TMA Committee on Environment.

"Low-level chemical exposur occur in both indoor and outdo air pollution," says Dr Mille "However, the indoor environme is the one that has been underest mated by everyone." Cases of "si building syndrome" are being link to exposure to low levels of chem cals. Persons living near toxic was sites and chemical processing plan are also experiencing low-lev chemical exposure.

"There seems to be a patter emerging. Chemical sensitivity is problem we are hearing more an more about, both on a nation scale and in Texas," she says. "W need to approach this emergin problem on a scientific basis. seems to be increasing in terms the number of people reportin problems and symptoms, but w don't have the tools to address adequately. Physicians already a knowledge that pollution can play role in asthma, but we don't hav any way as clinicians to approac specific patients and determine ho much of their asthma is due to env ronmental exposure. Epidemiolog cal studies suggest that there ar more cases of asthma among peopl living in urban areas, but that sti doesn't answer the basic questior What about this particular perso and his or her exposures?

"We see a lot of asthmatic chil dren in our allergy clinic. Onc we take exposure histories w find out they are exposed no only to dust and mold, but also t cigarette smoke and cleanin agents, all of which are irritant and may be playing a bigger rol in causing their symptoms tha we have acknowledged in th past," says Dr Miller.

An indoor air pollution inciden Dr Miller is familiar with, sinc she once served as a consultant fo the Environmental Protectio Agency, involved one of the agen cy's own facilities. "The agenc had installed 27,000 square yard of new carpeting in their head quarters located in a mall-lik building that was not intended fo

PESTICIDES

t an be a Catch 22. The task is to make sure the ks of pesticides to human health and the environment work in harmony with the safe use of pesticides. Physicians will find that their patients not only being exposed while on the job, but o at home.

WHAT IS IT?

- A variety of chemical agents used to control or kill unwanted animals or plant life.
- Pesticides include insecticides, rodenticides, herbicides, fungicides, and defoliants.
- Pesticides are used in agriculture and home/commercial lawn and garden projects, but are also found in swimming pools to combat bacteria and algae; animal sprays and dips; industrial preservatives to manufacture such items as paint, disposable diapers, and in hospitals.
- Pesticides are regulated by the Environmental Protection Agency. The Food and Drug Administration and the US Department of Agriculture enforce EPA regulations.

WHAT IS THE DANGER?

- Humans can be exposed through food, air, or water.
- Pesticides can enter the body through three paths: breathing in fumes or dust, absorption, or ingestion.
- Use of over-the-counter pesticides at home can result in exposure.
- Small quantities of pesticide are consumed through field-grown, raw agriculture commodities. Pesticides have also been found in wild game, fish, and birds.
- Water can also be a route of exposure. The application of pesticides can lead to run-off into rivers, streams, and creeks.
- Airborne exposure can occur during application of pesticides.
- Potential for injury from pesticides is based on toxicity of the active ingredient; dose; route of absorption; duration of exposure; and physical and chemical properties.
- Signs of pesticide poisoning include fatigue, malaise, sleeplessness, headache, dizziness, heavy perspiration, blurred vision, vomiting, muscle pain, stomachache, and cramps. More severe symptoms include anemia, peripheral neuropathy, convulsions, and delirium.

WHAT CAN PHYSICIANS DO?

- Identify patients who are at high risk for pesticide poisoning. Occupations at high risk are ground applicators, gardeners, nurserymen, landscapers, farmers and ranchers, field workers, pesticide transporters, manufacturers, fumigators, aerial applicators, police officers, firefighters, and structural pest control operators.
- Alert patients to the dangers of pesticide use. Urge them to read labels on pesticide containers.
- The 1985 Texas Occupational Disease Reporting Act requires the reporting of acute occupational pesticide poisoning. Information to be reported includes patient's name, address, age, sex, race/ethnicity, diagnosis, date of diagnosis, and name of physician. Cases can be reported to local health authorities, Texas Department of Health staff, or to the TDH Bureau of Disease Control and Epidemiology by calling (800) 252-8239.
- Answers to pesticide questions can be found by using the following resources: North Central Texas Poison Center, (800) 441-0040; Statewide Poison Center, (800) 392-8548; National Pesticide Telecommunication Network, (800) 858-7378; Texas Agriculture Extension Service, (409) 845-7026; EPA, Region 6, (214) 655-7239; Texas Department of Agriculture, (800) 832-7347.

Sources: Texas Department of Health and Environmental Protection Agency.

se as office space. The ventilation was not adequate and hundreds of workers developed headaches, breathing difficulties, and problems with concentration, along with eye, nose, and throat irritations. Out of that group there are dozen or so individuals who now report marked sensitivities to many common chemical exposures. Some have left their jobs; others now work in a specially constructed and well-ventilated office area.

"In terms of having an impact on national health, the indoor environment is on the average more important than outdoor exposures," says Dr Miller, "although I wouldn't downplay outdoor pollution, especially if you live downwind from a factory or near a toxic waste site.

"Environmental medicine is a

huge topic," says Dr Miller. "And to say this is something the physician needs to know more about is an understatement. We hear so much in the media regarding environmental concerns that we become almost immune. We don't stop to consider that the patients we see on a daily basis may be affected by these exposures."

Water: bad news on the border

"When I was a boy I used to go swimming in that river; now I wouldn't stick my big toe in it."

Laurance N. Nickey, MD, has a love/hate relationship with the Rio Grande River, which forms the border between the United States and Mexico.

"The Rio Grande is one of the most polluted rivers in the United States," says Dr Nickey, who serves as chairman of TMA's Council on Public Health. "It is terribly contaminated with human excrement and chemicals." And, he stresses that what happens on one side of the river happens on the other — immediately.

"We are just now beginning to climb out of this morass of environmental and public health problems," he says. Air pollution, improper disposal of medical waste, and open ditches filled with raw sewage — this is real life for the director of the El Paso City and County Health District and he wants others to know the dangers stalking the health of Texans.

"It is very difficult to have an understanding of the situation if you don't live the experience," he says. "It may take a cholera epidemic to make people aware of the problems." And "because disease knows no boundaries," any epidemic along the border ultimately threatens other portions of the state.

In the early 1900s, about 30,000 people called the border home. Now nearly 7 million people live there. Most Mexican cities have no proper sewage treatment facilities. In Juarez there is an 18-mile long, open sewage ditch called *aqua negra* ("black water") that runs parallel to the city limits of El Paso. "It is a potential source of enormous public health problems. In El Paso we have 58,000–68,000 people living in 350 *colonias* that either don't have potable water inside their homes, proper sewage connection, or both," says Dr Nickey.

"Oftentimes physicians are so busy in their own world," he says. "We have to make government regulators and agencies aware of the problem."

Paul Bronnenberg, a sanitarian for the Texas Department of Health water hygiene division, says the quality of water from public water systems is good in Texas. He adds that attention should be directed to the quality of untreated water found in lakes, rivers, and streams.

If patients do complain of water problems, either from public supplies or wells, Mr Bronnenberg suggests physicians advise their patients to have the water tested. Physicians who have water quality questions may call the TDH water hygiene division at (512) 458-7497.

Know thy patients

Where your patients live, work, and play may help you diagnose an environmental-related illness. An expanded health history with questions concerning environmental life-styles may be beneficial. You might consider asking the following questions:

- What types of hobbies do you participate in?
- How old is your home and where is it located? Are you remodeling?
- Are you using pesticides in your garden or on your yard?
- Do you live or work in an area where there is a high level of air pollution?
- Have you ever noticed an unusual odor or taste in your water supply?
- Do you live or work near an oil refinery, petrochemical plant, manufacturing plant, or industrial park?

Patients' responses to these questions may provide you with important clues for solving an environment-related illness mystery. ★

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Medical Economics

Medicaid RBRVS payment system begins April 1

THE TEXAS DEPARTMENT of Human Services Board, upon the recommendation of the Physician Payment Advisory Committee (PPAC), has voted to institute a resource-based relative value scale payment system for Medicaid payments.

Barring any last-minute changes, the new payment system, based on the Medicare model put in place in January, was scheduled to go into effect April 1.

The new system, like its Medicare counterpart, will boost reimbursements to primary care physicians, while cutting fees for some surgery and certain other procedures. According to Mike Dabbs, TMA's director of quality assurance and utilization review, the changes will hopefully make it possible for more physicians to accept Medicaid patients.

"We hope that with the increase in reimbursement that this program will bring, many more doctors will be able to provide care to Medicaid patients," he said. "Increasing access was one of the main goals of the PPAC."

The 15-member committee, with 10 physician members, was formed in April 1991 to study alternative payment systems and recommend changes to improve access. The committee identified major problems with Medicaid as being a vastly increased eligible Medicaid population, particularly children and pregnant women, and a decreasing primary care physician provider base willing to serve new Medicaid patients. The primary reason for physicians departing from the program was reimbursement, which was considerably less than the physician's cost of practice, particularly for primary care.

In recommending the RBRVS system based on the Medicare model, it recommended adding several elements to the program to make it more flexible, a concept generally endorsed by TMA, according to Mr Dabbs. The major changes are:

- No phase-in period. The fee scale took effect in full force on April 1.
- The conversion factor is set at $26.873.
- There will be no geographic practice cost index (GPCI). Without GPCIs, the ultimate fee paid is the same or very near the Medicare fee, even with a lower conversion factor.
- The use of Access Based Reimbursement Fees (ABRF) allows Medicaid to make exceptions to the RBRVS in order to meet unique Medicaid service needs.
- The Texas Medicaid RBRVS scale is not budget neutral. It will provide an additional $45–$50 million in physician payments, focused mainly on primary care.

> "WE HOPE THAT WITH THE INCREASE IN REIMBURSEMENT MANY MORE DOCTORS WILL BE ABLE TO PROVIDE CARE TO MEDICAID PATIENTS."

Under the ABRF provisions, several exceptions to the RBRVS have already been approved by DHS. Among them are:

- Neonatal care paid at a higher rate.
- Obstetric care paid at a higher rate.
- Emergency care paid at a lower rate than RBRVS, but still repr[illegible] senting an average increase ove[illegible] previous Medicaid payments.
- Surgery to correct strabismu[illegible] paid at a higher rate.
- Sterilization procedures paid at [illegible] higher rate.
- Anesthesiology conversion factor [illegible] set at $15.32, up fro[illegible] $13.94, except for ob[illegible] stetrical and steriliza[illegible] tion procedures, whic[illegible] are paid at a $17.9[illegible] conversion factor.

Mr Dabbs said TM[illegible] staff will be rigorousl[illegible] monitoring the new sys[illegible] tem and will propos[illegible] fine-tuning and other ad[illegible] justments as necessary[illegible] The PPAC, he added, i[illegible] willing to review propos[illegible] als from any specialty so[illegible] cieties for changes to th[illegible] new system.

Once the system is u[illegible] and running, TMA plan[illegible] to publish a Medicaid fe[illegible] schedule and Medicai[illegible] guide for Texas physi[illegible] cians, Mr Dabbs said[illegible] For more information[illegible] contact him at (800) 880-1300 o[illegible] (512) 370-1400.

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

Election year brings out health-care reform plans

EVER SINCE A RELATIVEL[illegible] unknown Democrat, Harri[illegible] Wofford, defeated heavily fa[illegible] vored Republican Richard Thorn[illegible] burgh last November for a US Sen[illegible] ate seat from Pennsylvania, the issu[illegible] of health-care reform has been o[illegible] the minds and lips of almost ever[illegible] politician in the country.

Mr Wofford, an academic who ıd previously not held elected office, ın on a platform of "national health ısurance" and captured the attention f voters, who swept him into office ith a 340,000 vote margin.

Though opinions remain divided long party lines as to what the Wofrd victory in Pennsylvania really ıeant, the factors that brought the isıe to the forefront have been with us r some time: 34 million Americans ithout health insurance, health-care osts rising at four times the rate of nflation, and more and more small usinesses dropping insurance beause of costs, to name a few.

But the issue is not a new one to exas physicians. TMA leaders have rappled with the issues on several ronts in the past few years.

"The Texas Medical Association s acutely aware of the problem of ccess to affordable health care; the ffordability of health care has beome a major policy concern," said aren Batory, TMA director of ıealth care delivery. "Increasingly, olicymakers are concerned with ontrolling runaway health-care osts while maintaining access to afordable health insurance. The proiferation of health access reform roposals over the last 4 years indiates fertile ground for modifiations to the current health-care deivery system."

Between 1989 and 1991, the Texas Medical Association spearheaded a coalition of consumers, egislators, government officials, and hysicians to develop a plan called "Insuring the Uninsured: A Plan for Texas." This plan outlined a fivestep approach to assuring access to affordable health care.

Since that plan's publication, TMA has been tracking trends to delineate TMA policy on the various components of health reform, and the results of that effort are shown below. The areas covered are general approach/financing of reform, cost containment, health insurance reform, targeted populations (small employers and working poor), quality concerns, and professional liability. The main proposals are outlines for each area, and TMA policies pertaining to those areas are in bold type.

Major Health-Care Reform Proposals

General approach/financing

- *Universal access proposals*
  1. A social insurance program in which services are financed through general revenues but are furnished by independent providers, as in Canada.
  2. A national health service in which government finances and furnishes health-care services, as in Britain.
  3. A public-private program in which government shares the financing burden with employers, but health care is provided by independent providers.

  TMA opposes national health insurance, seeking to preserve private, personal, medical and health care by building upon the existing system of private health insurance. TMA should not support new federal programs that add to the tax burden and fiscal inflation, and encourage deficit spending. ("National Health Insurance," *TMA Policy Manual*, November 1989.)

- *Mandate employer health insurance*
  Impose federal mandate on employers to provide coverage or pay a portion of public plan coverage for their workers, or provide specific benefits.

  TMA supports a "moratorium on mandated coverage until a more comprehensive understanding of its impact on health care costs can be achieved." ("Mandated Coverage," *TMA Policy Manual*, November 1989.)

- *Expand existing public programs*
  1. Extend Medicaid/Medicare programs to cover more eligibles.
  2. Allow employers/individuals to "buy into" the Medicaid program.

  TMA supports expansion of Medicaid and development of a sliding scale entitlement program based on Medicaid for the working poor with incomes below 250% of poverty. (Ad Hoc Committee Report, 1990.)

- *Provide tax incentives to make health insurance more affordable.*
  1. Tax credits to employers.
  2. Tax credits to employees to be offset against income taxes.

  TMA supports the concept that health-care expenditures are to be tax deductible. ("Competitive Insurance Models," *TMA Policy Manual*, May 1989.)

Cost containment

- *Use effective utilization review programs.*

  TMA policy states that the design and implementation of UR programs should be controlled by physicians. Review should be done uniformly across all programs, provide for flexibility, and be evaluated through trial periods before UR program is linked with claims processing.

  TMA policy also states that UR programs should consider local circumstances and initiatives.

  TMA policy seeks to minimize the Federal Trade Commission's (FTC) role in defining professional scope of practice and wants to lessen the FTC's prohibition on peer review of physician charges by grievance and

insurance review committees. ("Utilization Review," *TMA Policy Manual*, May 1989.)

- *Practice patterns*
  TMA policy encourages members to evaluate their practice patterns to reduce and improve the utilization of health-care resources. TMA policy also encourages insurance companies to support cost containment by recommending the least expensive setting in which a procedure can be performed safely and effectively. ("Cost Containment," *TMA Policy Manual*, May 1989.)

- *Use managed care*
  TMA is supportive of multiple systems of medical care delivery, recognizing that a variety of health-care delivery plans offers patients the greatest freedom of choice and the best opportunity for further improvements in health care. ("Freedom of Choice," *TMA Policy Manual*, May 1989.)

- *Develop a basic benefit package*
  TMA recommended creation of a basic benefit package for small employers who have fewer than 25 employees. (Ad Hoc Committee Report, 1990.)

- *Increase consumer accountability in the health-care equation*
  1. Encourage incentives for wellness behavior (eg, premium discounts to nonsmokers).
  2. Institute higher deductibles and copayments.
  TMA policy recognizes that every responsible person has the primary responsibility for his or her own health, as well as the health of their dependents. ("Responsibility for Health," *TMA Policy Manual*, May 1989.)

  TMA policy opposes cigarette smoking. ("Smoking," *TMA Policy Manual*, May 1988.)

Reform debate centers on five basic plans

IT'S A HEALTH-CARE REFORM JUNGLE out there: Some 40 health-care reform bills have been filed this session of Congress, and almost every organized interest group from the AARP to the Heritage Foundation has put forth or supports one plan or another.

But all the plans proposed thus far, give or take a few bells and whistles, fall into 5 basic categories:

Comprehensive single payer (also known as the Canadian model) — A fully public, single-payer system, administered by states under federal guidance. It would provide universal health coverage at no out-of-pocket costs to individuals, would reimburse doctors on a national fee scale, would base hospital payments on global budgets, and would limit health-care expenditures' growth to that of the Gross Domestic Product (GDP).

Employer-based health care ("pay or play") — Employers would choose between providing health-care coverage for employees and their dependents or paying a tax equal to a small percentage of their payroll (between 7% and 10%) to bankroll a Medicare-like public program. This plan would control costs through limiting growth of expenses to the rate of increase in the GDP and would reimburse providers on a Medicare-type fee schedule.

Medicare extender (government as single payer) — The government would become the sole payer of health-care benefits, with private insurers acting as intermediaries. Each insurer would be paid a capitated fee for each person enrolled in its plan, or plans. Cost containment would be achieved by incrementally limiting growth to rate of increase in GDP. The plan would cover all low-income individuals with comprehensive benefits without deductibles or coinsurance; private insurance would offer Medigap-type supplemental benefits to others.

Market-based reforms (President Bush's plan) — This plan would leave the current system in place, but would increase access by granting tax credit or voucher up to $3,750 per year to purchase health insurance; would control costs by encouraging the formation of health insurance networks; would eliminate waste by capping malpractice suit awards, reducing mandated benefits, and mandating computerized claims; and would eliminate "preexisting condition" limits.

Health Access America (AMA plan) — This plan would require employers to provide health insurance for all full-time employees and dependents with tax help to employers; reform the financing of Medicare through a phased-in program of pre-funded vouchers; improve financing of long-term care through a public/private program, including availability of asset protection coverage; protect those not covered by employer-based insurance or Medicare through a reformed Medicaid plan; create state-level risk pools to assure coverage for the medically uninsurable; and amend ERISA to equalize treatment of self-insured plans to those of state-regulated insurance plans, including the repeal of state-mandated benefit laws.

Health insurance reform

- *Underwriting reform*
  Rate banding to limit difference between new and old businesses of same class.
  TMA recommends rate banding. (Ad Hoc Committee Report, 1990.)

- *Mandated benefits*
  Evaluate cost-effectiveness of mandated benefits.
  TMA recommended a legislative review of costs associated with mandated benefits. (Ad Hoc Committee Report, 1990.)

- *Reinsurance pools*
  Use reinsurance pool to ensure high risk individuals are not excluded from group coverage.
  TMA recommended creation of a reinsurance pool. (Ad Hoc Committee Report, 1990.)

- *ERISA reform*
  Needs to be greater regulation of ERISA plans, including mandatory participation in state guaranty fund, payment of state premium taxes, and provision of a basic package of benefits.
  TMA supported ERISA reform. (Ad Hoc Committee Report, 1990.)

Targeted populations

- *Create affordable benefits package for small employers with fewer than 25 employees.*
  1. Allow high-risk individuals to be insured through a reinsurance mechanism.
  2. Limit application of preexisting waiting periods.
  TMA policy supports development of an affordable benefits package. Endorses reinsurance mechanism and limitations on application of preexisting conditions. (Ad Hoc Committee Report, 1990.)

- *Develop a plan of affordable benefits for the working poor (incomes of less than 250% of poverty) who cannot obtain health care.*
  Plan could be administered by the state (eg, "Medicaid Buy-in").
  TMA policy supports development of a sliding scale entitlement program for the working poor. (Ad Hoc Committee Report, 1990.)

Quality elements

- *Scope of Practice Issues for all providers*
- *Assure delivery of health care services is based on measures of medical necessity.*
  Assure health care is delivered appropriately, effectively, and efficiently to all consumers to make better health-care decisions through development of professional practice parameters.
  TMA policy supports the current structure of the health-care delivery system against efforts by non-physician health-care workers to expand their scope of practice and secure mandatory third party reimbursement. ("Allied Health," *TMA Policy Manual*, November 1988.)

Professional liability

- *Tort reform*
  Reduce costs of care through professional liability reform.

- *Indemnification*
  Provide incentives for physician participation in state-funded indigent care programs.
  TMA policy supports the 1989 State Indemnification Program.

Some physicians getting "sticker shock" from RBRVS fees

LIKE CAR BUYERS GETTING their first look at how much a shiny new model costs, some Texas physicians getting their first claims back from Medicare's new RBRVS fee scale are going through "sticker shock."

Some fees, particularly those of general surgeons, have dropped between 20% and almost 40% for some common procedures. (See chart, next page.)

According to Louis Goodman, PhD, TMA director of medical economics, the main reason for the huge cuts Texas physicians are seeing is the poor data the federal government used in calculating the geographic practice cost indexes (GPCIs) for Texas. The chart shows last year's payment and what the final payment will be when RBRVS is fully implemented in 1996.

"If the RBRVS system was put in place today, without any of the updates and modifications or the transition period, this is what it would look like," he said. "It is kind of a perverse set of incentives. On the one hand, the transition is to cushion the implementation of the plan, which is what we wanted. But, when the plan is fully implemented, there is going to be quite a difference in what physicians are paid now and what they will be paid."

Dr Goodman said such numbers are one of the reasons that TMA and AMA will not endorse the RBRVS system until substantial changes are made. In December, the AMA House of Delegates listed several major changes it wants made in the program before it will endorse it:

- Prevention of any further reductions of the current Medicare policy regarding limiting charges.

- A second Medicare participation decision period between June 1 and July 1, 1992, to allow physicians to reconsider the decision they were forced to make in December 1991 based on very limited information.

- Replacement of current flawed proxy data basis for Medicare's GPCIs with current data that reflect actual practice overhead costs.

- Relief for such inequities as lack of any payment for interpretations of EKGs, discriminatory payment reductions for "new" physicians, surgery, and "new" patients, and a 50% copayment for mental illnesses.

Impact of Medicare fee schedule in selected areas in Texas.

1991 Medicare fees for internists and general surgeons compared to fully implemented Medicare fee schedule for s lected CPT-4 codes.*

		Houston			Dallas			Rural West Texas		
CPT-4 Code	Description	1991 Fee ($)	RVS Fee ($)	Change	1991 Fee ($)	RVS Fee ($)	Change	1991 Fee ($)	RVS Fee ($)	Chang
Internists										
90260	Typical hospital visit (IM)	35	31	-11%	35	30	-14%	23	28	22%
90030	Typical office visit (IM)	24	22	- 8%	24	22	- 8%	14	20	43%
90014	New patient visit (IM)	60	54	-10%	60	53	-12%	52	50	-4%
General Surgeons										
49505	Repair inguinal hernia	475	324	-32%	436	315	-28%	388	293	-24%
33207	Insert heart pacemaker	758	558	-26%	807	544	-33%	671	501	-25%
47605	Gallbladder removal	794	645	-19%	782	627	-20%	747	583	-22%
58150	Total hysterectomy	830	782	-6%	811	761	-6%	759	709	-7%
66984	Remove cataract, insert lens	1,312	924	-30%	1,352	907	-33%	1,214	781	-36%
27132	Total hip replacement	2,384	1,834	-23%	2,342	1,784	-24%	2,176	1,637	-25%
33512	Coronary artery bypass	3,257	2,413	-34%	3,407	2,083	-39%	2,964	1,912	-35%

• *RVS fees represent what would be paid beginning January 1, 1992, if the fee schedule were fully implemented then. In actuality, 1992 fees are a blend of the fee sche ule amount and updated 1991 fees.*

Dr Goodman said the GPCIs are the main cause of the low numbers in Texas.

"The GPCIs are the only factor that differs between Houston, Dallas, and West Texas," he said. "That's where we are focusing our efforts, on getting HCFA to clear up the problems caused by the flawed GPCIs in Texas."

(See "TMA garners congressional support for GPCI changes," p 60.)

Mark your calendar for practice management seminars

FEELING OVER-REGULATED? Overexposed? Maybe even overworked? Physicians in the '90s face more regulation, risk of liability, longer hours, and less time for themselves and their families than ever before.

With that in mind, TMA's practice management department has scheduled dozens of workshops and seminars for 1992 to help you cope in these complicated times. Most workshops are scheduled in various cities around the state. Mark these programs on your calendar now.

Coding and Collecting in the '90s, workshop to help you cope with th new CPT-4 coding system.

April 10	**Fort Worth**
April 14	**Lubbock**
April 16	**Amarillo**
April 21	**Houston**
April 22	**Corpus Christi**
April 28	**San Angelo**
September	**8–10 cities**

OSHA and Infection Control, a 3-hou afternoon workshop for physician office managers, or staff member responsible for infection contro management. The workshop pro vides handout materials on the ne OSHA rules and regulations, inclu

g a 35-page prototype plan to lapt for your practice.

April 21	Tyler
April 22	Austin
April 23	San Antonio
April 24	Dallas
April 28	Fort Worth
April 29	Amarillo
April 30	Houston
May 1	Corpus Christi

om Deposition to Courtroom, a workhop designed to help physicians ass and limit their exposure to medal liability claims. Also fulfills HB 8 risk management requirements or CME and insurance discount.

April 23	Dallas
May 21	San Antonio
June 11	Houston
August 27*	Houston
September 19	Austin
October 22	Dallas
November 19	San Antonio

* *Date changed from August 20 to avoid conflict with Republican National Convention.*

nproving Patient Service

June 9	Houston
June 10	Dallas

uilding a Team, a workshop for office nanagers.

May 7	Dallas
May 14	Houston
May 21	San Antonio
October 8	Amarillo
October 9	Dallas
October 13	Houston

Assertive Compassion, a risk management workshop for office staff.

July 15	Austin
July 16	Amarillo
July 22	Tyler
September 9	Dallas
September 10	San Antonio
September 17	Houston

Medical Office Management Institute

July 7–10	Dallas
July 21–24	Houston
August 11–14	San Antonio

Workers' Compensation/Level of Service

July/August	8 cities

Estate Planning for Physicians

October 1	Dallas
October 3	Dallas
October 8	Houston
October 10	Houston

Practice Management Series

October	4–5 cities

How to Get Started in Medical Practice

November/ December	4–5 cities

Medicare Update

November/ December	8–10 cities

How to Run a More Profitable Practice

December	4–5 cities

For more information about these programs, particularly those without specific dates, or to register, contact the TMA practice management department at (800) 880-1300 or (512) 370-1421.

RBRVS BRIEFS

The following items contain information prepared by TMA's healthcare financing staff to help physicians better understand the new Medicare RBRVS payment system.

Lack of modifier blocks claims payment

Computer programs at the Medicare carrier are suspending payment of physician claims that the computer thinks require modifier 25. In a single week in February, the processing of more than 21,000 such claims from Texas physicians was stopped — some of them incorrectly — while letters requesting additional information were sent.

Physicians should use modifier 25 to bill for a procedure and a separately identifiable evaluation and management service performed in the same day. The modifier is used only in cases in which the patient's condition requires an evaluation and management service that is above and beyond the usual pre- and postoperative care for the procedure. Medicare will pay claims that use the modifier generally without requesting additional information, although the likelihood of postpayment review is high.

Many of the claims incorrectly suspended are ophthalmology claims that include the new CPT code 92015, determination of refractive state, plus a visit code. Simply returning these claims to Medicare with the notation "no surgery performed" will obtain payment. Otherwise, returning Medicare's correspondence with modifier 25 added where appropriate should be a sufficient response.

Dissecting the global surgery payment

Under Medicare's new national global surgery policy, surgeons who provide less than the full surgical package are having their Medicare payment reduced to reflect only the portion they actually performed. Previous Medicare policy did not require a reduction in payment to a physician who only performed the surgery.

Now, a physician who performs only surgery and leaves postoperative care to another physician should file a claim using modifier 54 (surgery only). A physician who provides postoperative care should file a claim for the surgical procedure using modifier 55 (postoperative management only). Medicare will seek repayment from surgeons who fail to use modifier 54 in appropriate circumstances.

Global billing does allow the attending physician to receive additional payment for providing services unrelated to the original procedure. Modifier 24 should be for an unrelated evaluation and management service during the postoperative period; modifier 79 should be used for an unrelated procedure or other service.

New physicians aren't what they used to be

Medicare's implementation of legislatively required cuts in payments to physicians during their first 4 years of practice has resulted in confusion about who is a "new" physician. Medicare determines the beginning of a new physician's career by the date of his or her first billing to Medicare. These suggestions can help some physicians now classified as new:

- Many physicians just starting in practice can qualify as being in their second year or beyond if they filed a Medicare claim while moonlighting during residency.

- In some instances, physicians who are beginning to practice in Texas after having practiced elsewhere are being classified as new physicians because the Texas carrier has no record of their having billed Medicare. Medicare will change a physician's status if documentation of previous payment from a Medicare carrier in another state can be provided.

Many physicians with years of practice are being classified as new physicians because they never filed a Medicare claim. Particularly hard-hit are physicians trying to establish a civilian practice after a military career. Under HCFA's interpretation of the law, only new legislation can change the status of these physicians.

Avoid concurrent care complications

Completing and returning Medicare's specialty classification survey can help speed up claims payments and avoid concurrent care denials. The new survey includes several specialties previously not noted on Medicare's records. The elimination of the concurrent care modifier 75 from the 1992 CPT book has increased the importance of accurate specialty classification.

Medicare is trying to reduce confusion by surveying Texas physicians about their specialty designations so that claims by physicians in different areas can be accurately identified and paid. Physicians who have not returned the survey for that was sent in January should c so at once. The X6 modifier, whic was used in Texas to note sever specialties not in Medicare's record has also been eliminated.

Complex injection codes explained

Medicare payment for administr tion of injections now depends c whether the patient received ar other services at the time of the i jection. The rules are complicate but physicians can apply them m chanically:

- Payment for injected drugs: Med care coverage of the drugs then selves remains unchanged. Phys cians are reimbursed the lower c the actual cost of the drug or i average wholesale price. Use th HCPC's J codes to specify th drug actually injected. Separat payment for the drug will b made whether or not any add tional services were provided o the day of the injection.

- Injection administration code Medicare will pay a separat charge for administering injec tions only if the physician pro vides no other services on tha patient that day. The most com monly used codes in filing fo this service are the therapeutic c diagnostic injection codes 9078 and 90784. The one exceptio is in the administration o chemotherapy. Although a fina decision has not been made Medicare will likely not pa more than a single injection cod fee even if multiple injections ar administered.

- Other services: If a physician provides a visit or any other service on the same day as an injection, Medicare does not pay a separate charge for administering the injection but it does pay for the drug.

- Chemotherapy: Medicare allows physicians providing cancer chemotherapy with a documentable visit to the patient to charge for a visit and administration of chemotherapy (codes 96400 through 96549) on the same day. An additional payment is made for drugs used.

or more information or assistance ith any of the above or other Iedicare payment issues, call Pat offey, TMA physician reimbursenent specialist, at (800) 880-1300 r (512) 370-1416.

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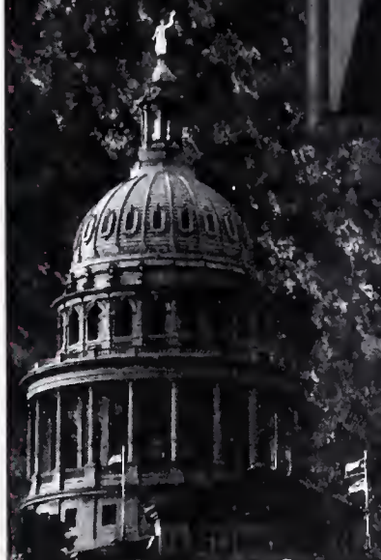

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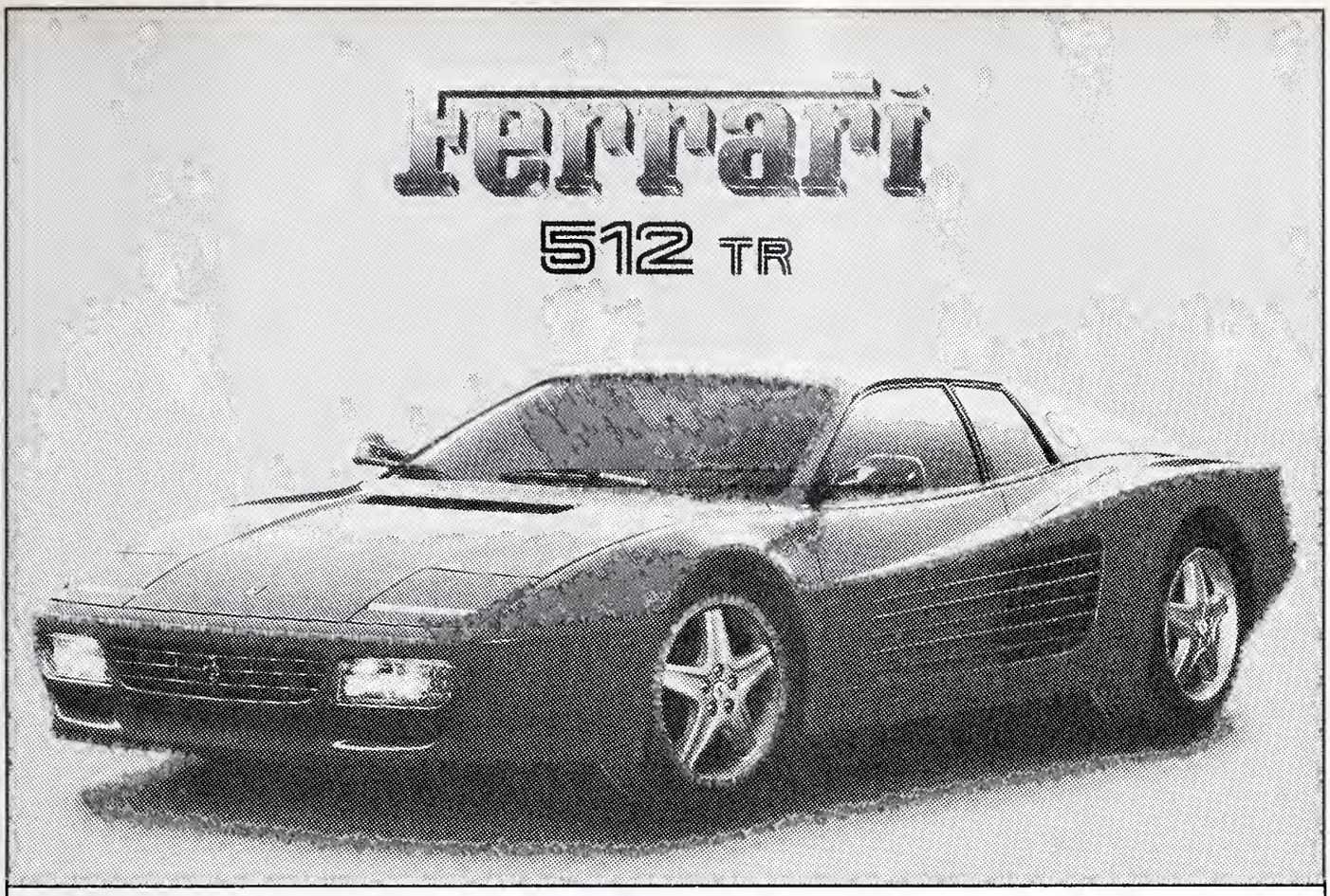

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Public Health

TDH commissioner calls for streamlined system

THE NEW COMMISSIONER of the Texas Department of Health has hit the floor running with plans on how to provide better health care for Texans.

David Smith, MD, took office in March after working as director of Parkland Memorial Hospital's community health clinics. The 38-year-old pediatrician was selected by the TDH board in February.

In an interview shortly after his appointment in mid-February, Dr Smith talked about some of the challenges he faces.

"We need to rethink ways we deliver care in both the public and private sectors," he says. Attention needs to be directed toward "regional health-care issues and ensuring that we knock down some barriers of time, distance, culture, and transportation.

"One of the largest areas of capacity for the practice of comprehensive public health is the private sector," says Dr Smith. "The challenge, of course, is not to place an undue burden on that part of the health-care delivery system.

"At the same time physicians play a critical role in providing preventive treatment such as immunizations," says Dr Smith. "I think we have to look at how we can make those things happen in an expeditious fashion." He is also interested in developing reimbursement patterns that reward practitioners and patients for practicing preventive health.

Pap smears, immunizations, and breast self-examinations should be available to all patients, he says.

David Smith, MD

"We know all these procedures are beneficial to patients," says Dr Smith. "We are making gains, but we are not as far as we should be at this time."

The "fragmentation and disjointedness" of services provided to patients in the health-care system is a concern of Dr Smith's.

And the amount of paperwork generated by the health department also concerns him. "We kill too many trees daily in East Texas," he says. "The numerous forms and processing for eligibility really hamper the job we should be doing. I think it is just plain inefficient and there are cost savings to be realized."

Issues surrounding children's health along with trauma care and the environment also have attracted Dr Smith's attention.

"It is a tragedy that we are seeing fewer than 40% of our 2-year-olds adequately immunized," says Dr Smith. "I will be a strong advocate for child health in the comprehensive sense. Different opportunities need to be considered to impact their health in nontraditional settings. This can be accomplished in some nontraditional settings, such schools and churches, by workir closely with the family."

Prior to his employment wit Parkland Memorial Hospital, D Smith was an administrator with th US Health and Human Services Ac ministration in Washington, DC. H is a graduate of Cornell Universit and the University of Cincinnati medical school.

Harris County program educates physicians, patients on family violence

PATIENTS NEED TO REALIZ their doctors are concerne about family violence. This the message being sent through program developed by the Harri County Medical Society (HCMS Committee on Sexual Assault an Domestic Violence.

The program, which begins th month, is designed to educate phys cians and patients about domesti violence prevention.

"All physicians are aware of th problem," says Diana Fite, MD chairman of the HCMS violence pre vention program. "It is a topi sometimes difficult to address an we assume our own patients are nc involved. Our patients need to know that we consider violence a medical ly significant problem and that w are willing to discuss it."

The committee has planned sev eral activities in April to encourag communication between physician and patients on the subject of famil violence. Approximately 2,500 pri mary care physicians will receive lapel button with the message "Fam ily Violence Hurts Everyone." A list

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

AGENDA ON AIDS

Pediatric AIDS cases blamed on mothers

Mothers were to blame in 65% of diagnosed cases of AIDS involving their children, according to the Texas Department of Health Bureau of HIV nd STD Control, HIV Division. The children diagnosed were infected by ıeir mothers either during pregnancy or delivery (perinatal transmission). Mothers were infected as a result of personal drug use, IV drug use by their ex partner, or sex with an infected man where no drug use was reported.

My patient population is predominately female. Are they at any significant risk from HIV infection?

Over the last 2 years about one out of every eight AIDS cases was diagnosed in a woman. In some eastern states, that is one in four cases. The otal number of AIDS cases in women at present (over 22,000) is equal to he number of male AIDS cases in 1986. With regard to gender, HIV infection seems to be an equal opportunity disease. Thus, any sexually active voman who is uncertain of her present or past partners' HIV status should e evaluated for HIV infection. This is also true of any woman who has ised or is using intravenous drugs. You may want to include questions bout sexual practices and IV drug usage in your history taking. HIV testing vould then be appropriate for women who have had sexual partners whose HIV status is unknown or who use or have used IV drugs.

Richard M. Grimes, PhD, director of the AIDS Regional Education and Training Centers for Texas and Oklahoma at The University of Texas at Houston School of Public Health, will provide answers to questions about AIDS each month in this column. For further information about his topic or any HIV topic, call the AIDS Helpline for Health Professionals at (800) 548-4659.

ng of numbers for family violence eferral agencies in the Houston-Harris County area will be provided o physicians. Patients will also have he opportunity to talk with physiians about domestic violence durng a Dial-a-Doctor program schedled for Wednesday, April 22.

"I think we have all sort of stuck our heads in a bag on this issue and ıot paid much attention to domestic iolence," says Clarence P. Alfrey, MD, president of HCMS. "HCMS ıas a long history of interest in the overall problem. The society has recognized that sexual assault and domestic violence are real problems."

The society's first efforts began in 1983 with a program developed to preserve evidence collected from rape victims following examinaions. This was followed by a nurse examiners program that provided education on the handling of sexual ıssault cases. In 1989 the committee produced the video, "Sexual Assault Examination of the Prepubertal Female." The video is designed to educate physicians and health-care workers on how to conduct physical examinations on children who may have been sexually abused or assaulted. For information on obtaining the video or other educational materials, contact the HCMS at (713) 790-1838.

The communication link between physician and patient is crucial to making an impact on reducing the incidence of violence.

"Many patients are embarrassed to mention the subject of violence with their doctors," says Dr Fite. "Family violence is spread among all types, those who have money and those who don't, those with an education and those without. It is something you don't expect to happen.

"Family violence injuries are easy to overlook," she says. "Patients may or may not show signs of abuse. One of the keys to identifying a victim is to suspect everybody."

Dr Fite recalls one case that involved a child with a broken elbow brought to the emergency room by her parents. The parents said the injury occurred when the child rolled out of bed. One week later the wife came to the ER with injuries she claimed were the result of a fall. The husband was very nice and concerned about the well-being of his wife and child. Dr Fite asked the wife, without her husband present, about the daughter's condition. At this time the woman started to cry and tell Dr Fite about the abuse she and her daughter had been experiencing.

The non-abusive parent often knows the situation, but is afraid to say anything because of the fear of abuse. "It is a vicious cycle you have to watch out for," says Dr Fite.

New CDC rules require informed consent for vaccines

Beginning April 15, 1992, physicians will be required to provide information on the risks and benefits of certain vaccines to their patients, according to new rules from the Centers for Disease Control (CDC), a unit of the US Department of Health and Human Services.

The final rules, which were published in the *Federal Register*, Oct 15, 1991, pertain to vaccines that immunize against diphtheria, tetanus, and pertussis (DTP); measles, mumps, and rubella (MMR); and polio. The information must be provided to the individual receiving the vaccine or the legal representative in the case of a child.

Although the final rules do not spell out penalties for failure to comply, TMA General Counsel Donald P. Wilcox, JD, stresses that the rules will be used as evidence of a new standard of care for physicians.

"All physicians who provide vaccines should carefully follow the new CDC rules, if for no other rea-

son than it's good risk management strategy," said Mr Wilcox. "Texas physicians just don't need to expose themselves to unnecessary risk."

The Texas Department of Health was scheduled to mail "Vaccine Important Pamphlets" to all physicians to assist them in meeting these new informed consent requirements.

Information to be given to patients includes description of disease, benefits and risks of vaccines, vaccination schedule, when vaccination should be delayed or not given, and what to look for and do after receiving the vaccine. ★

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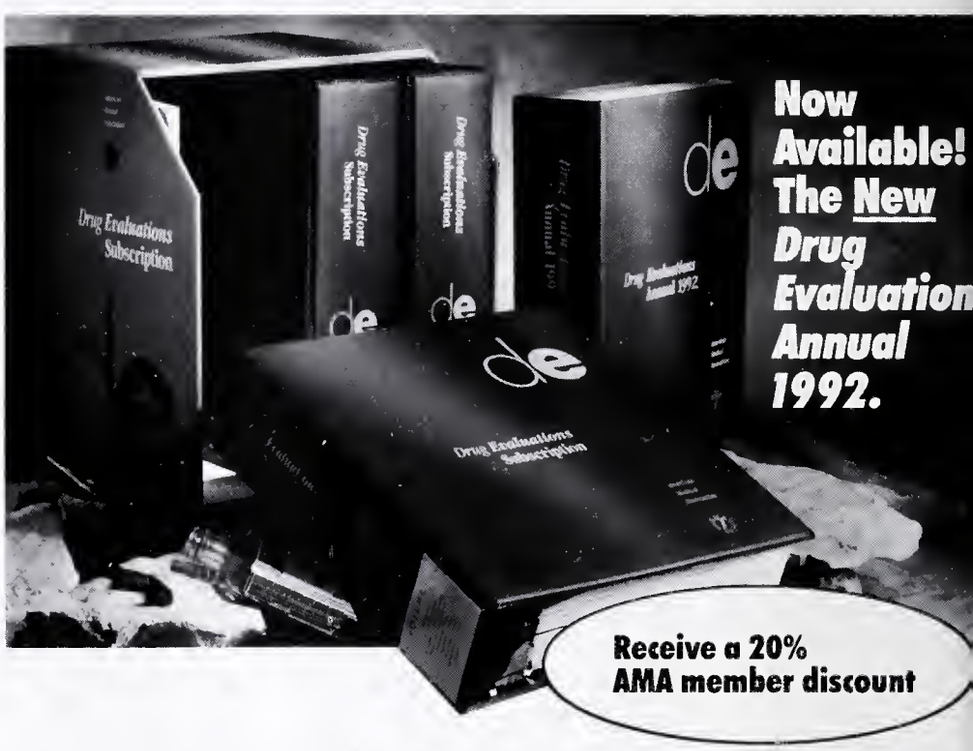

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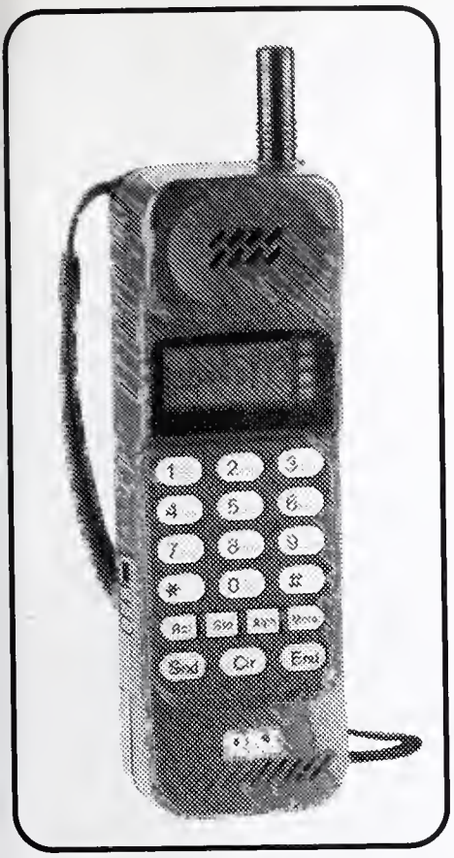

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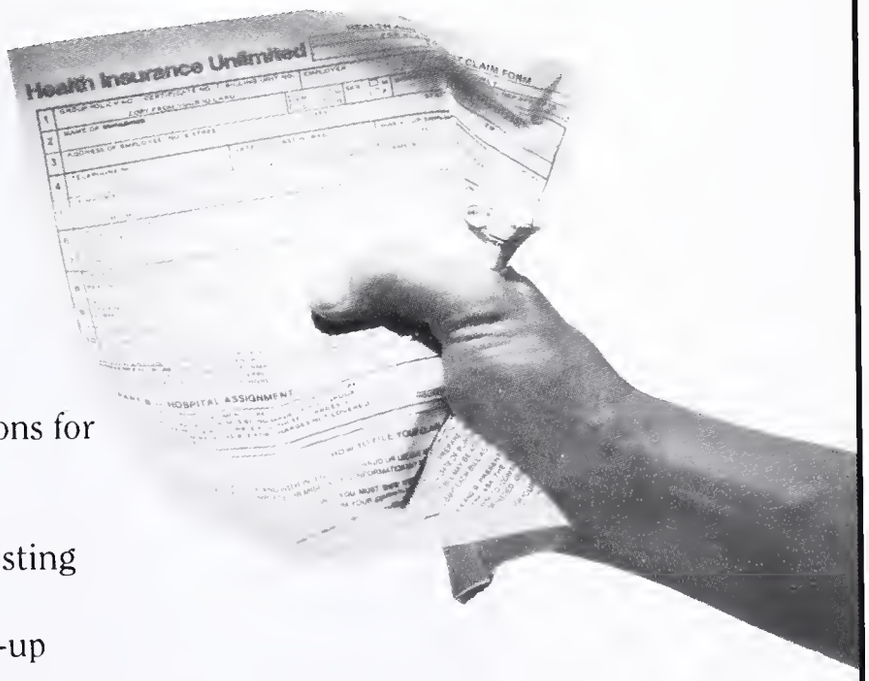

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Legislative Affairs

TMA garners congressional support for GPCI changes

IN THE WORDS OF TEXAS Medical Association President Sam A. Nixon, MD, "the seeds of legislative correction were planted" by physicians in January when a TMA delegation traveled to Washington, DC, for face-to-face meetings with Texas congressmen on problems with Medicare's geographic practice cost index (GPCI).

TMA leaders and staff on January 28 and 29 visited with 20 Texas congressmen and Senators Phil Gramm and Lloyd Bentsen in an effort to build support for legislation to require the Health Care Financing Administration to use valid and reliable data in calculating the so-called GPCIs. The TMA delegation also urged action to reverse a HCFA policy on payment for EKG interpretations and several other Medicare priorities.

Several Texas congressmen were expected to be cosponsors of legislation to be filed in early March to carry out the GPCI changes. In addition to requiring accurate data for calculating GPCIs, the bill also would require HCFA to work with state medical associations in developing the data. Data also would have to be updated annually.

"We were quite well received by each of the congressmen we visited, especially when they realized our proposal for correcting the GPCI errors is budget neutral," said Dr Nixon, who led the TMA delegation. Others involved in the meetings included President-Elect William G. Gamel, MD, Austin; Board of Trustees Chairman Alan Baum, MD, Houston; Council on Legislation Chairman Fred Castrow, MD, Houston; William Voelter, MD, Abilene; Howard McClure, MD, Dallas; Louis Gibson, MD, Corsicana; and Joe H. Cunningham, MD, Jacksonville. Also present were TMA staff members Kim Ross, Alfred Gilchrist, and Louis Goodman, PhD.

The GPCI used in calculating the Medicare fee schedule is based on 12-year-old data. As a result, the Medicare fees in many areas of the country, particularly rural areas, are significantly undervalued. For example, the professional liability insurance component for Texas is based on data from a carrier that only insures 153 physicians in the state.

"Each of them [the congressmen] agreed with us that it was wrong to penalize Texas patients and physicians by utilizing old and inaccurate figures in the calculations," Dr Nixon said. "If physicians drop out of Med care, it decreases access to care an patients are penalized by the bureau cratic, governmental inadequacies."

Dr Goodman said correcting th GPCI could increase physician pay ments under Medicare by tens o millions of dollars annually.

"Improving the GPCI is just lik the battle we won on the [resource based relative value scale] conver sion factor," he said. "Every penn increase translates directly into fee for service."

Mr Gilchrist, TMA director o legislative affairs, said he expect original cosponsors of the bill to in clude US Reps Ralph Hall (D-Rock wall), John Bryant (D-Dallas), Jo Barton (R-Ennis), and Mike Andrew (D-Houston). "But there'll be othe Texas congressmen who will be origi nal cosponsors, as well," he added.

TMA also has gained support fo the legislation from the America Medical Association and severa state medical associations, includin Louisiana, Georgia, Alabama, Ten nessee, and Arkansas.

Correcting the GPCI problem was only one of six Medicare legisla

US Rep Bill Archer (R-Houston) makes a point during discussions on Medicare payment reforms with Dr Sam A. Nixon.

TMA legislative affairs director Alfred Gilchrist (second from left) explains problems with the Medicare geographic practice cost index to US Rep John Bryant (D-Dallas). Listening to the discussion are Dr Joe Cunningham, Dr Fred Castrow, AMA staffer John Scott, and Dr Howard McClure.

Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs section of* Texas Medicine.

articles in Texas Medicine *that mention Texas Medical ociation's stance on state legislation are defined as islative advertising," according to Tex Govt Code Ann 5.027. That law requires disclosure of the name and ad- ss of the person who contracts with the printer to pub- the legislative advertising in* Texas Medicine: *Robert G. key, Executive Vice President, TMA, 401 W 15th St, tin, TX 78701.*

ve and regulatory priorities dis- ussed with Texas congressmen. An- her major problem discussed was ayment for EKG interpretations.

Current law does not allow pay- ent for EKG interpretation by a nsulting physician. For example, if n orthopedic surgeon judges that e cardiac status of an elderly pa- ent dictates that an EKG be per- rmed prior to surgery, he may have ouble finding a cardiologist to in- rpret the test because Medicare will ot pay the cardiologist's fee.

"There is no rationale for that ther than another cost containment easure," Dr Goodman said.

Other priorities presented to con- ressmen included:

- Maintaining balance billing limits for evaluation and management services at 140% of Medicare's allowed amount and 125% for all other services. The limits are scheduled to decrease to 115% on January 1, 1993.
- Repealing legislation reducing payment to new physicians during their first 5 years of practice.
- Reexamining HCFA surgical payment policies that are not based on any resource measurement, including payment for multiple surgical procedures, payment for bilateral procedures, and payment for treatment of postsurgical complications.
- Amending the hospital transfer law to require the Office of Inspector General of the US Department of Health and Human Services to hold pre-exclusion hearings before terminating a hospital from Medicare participation. The proposal also would change the standard of proof required for HHS to fine or exclude a physician or hospital from Medicare from "negligence" to a "knowing violation."

Senator Phil Gramm (R-Texas) and Dr Louis Gibson exchange views during a meeting on TMA Medicare priorities.

Dr William G. Gamel (right) listens to comments of Sen Lloyd Bentsen (D-Texas) during the January 28–29 meetings.

AMA staffer John Scott (left) and Dr William G. Gamel discuss proposed GPCI legislation with US Rep J.J. "Jake" Pickle (D-Austin).

TMA panel to monitor health-care reform debate

AN EIGHT-PHYSICIAN ADVISORY panel has been created by Texas Medical Association President-Elect William G. Gamel, MD, to monitor health-care reform proposals being debated by Gov Ann Richard's Health Policy Task Force.

Meanwhile, the governor's task force has scheduled public hearings across the state in April and May.

The TMA Health Policy Advisory Panel will be chaired by former TMA President Max C. Butler, MD, Houston. Other members include Joe Bailes, MD, McAllen; Jim Bob Brame, MD, Eldorado; Louis E. Gibson, MD, Corsicana; Hugh Lamensdorf, MD, Fort Worth; David Shulman, MD, San Antonio; former state Rep Michael D. McKinney, MD, Centerville; and Josie Williams, MD, Paris.

The panel, which held its first meeting February 27, will assist TMA staff in reviewing, analyzing, and preparing responses to major access to care and cost containment proposals being considered by the Health Policy Task Force. The panel also will make policy recommendations to appropriate TMA councils and committees.

"TMA needs to be involved in shaping health-care legislation at all levels," Dr Butler said. "We have to stay informed not only as to what the legislature is looking at, but also what is being looked at by all other interested parties, particularly the task force appointed by Governor Richards."

The 21-member Health Policy Task Force was appointed earlier this year by Governor Richards, Lt Gov Bob Bullock, and House Speaker Gib Lewis to study ways of ensuring access to health care for all Texans. Following organizational meetings in Austin, the panel initiated a series of hearings across the state. The first hearing was held in Tyler on February 20, with hearings in March in Lubbock, Abilene, and Dallas.

Further hearings have been set for McAllen, April 15; Houston, April 22; El Paso, May 5; and San Antonio, May 20.

Dr Butler said physicians in those areas should participate in the hearings and express their opinions on health-care reform to the task force. He also encouraged TMA members to express their opinions in writing directly to the task force. Written comments can be sent to the task force by writing Dr Shirley Chater, Chair, Texas Health Policy Task Force, PO Box 149133, Austin, TX 78714-9133.

Former legislator appointed to PPRC

FORMER STATE REP MIKE McKinney, MD, Centerville, has been named to a seat on the Congressional Physician Payment Review Commission.

Dr McKinney, who retired from the Texas House at the end of 1990, was appointed to a 3-year term on the commission that advises Congress about Medicare payment issues. He replaces former TMA President Jim Bob Brame, MD, Eldorado, who served two terms on the commission.

Dr McKinney said the major challenge facing the commission is access to health care.

"The commission is going to have to address the same thing the presidential debate is addressing — that is, how we are rationing health care," he said. "Dollars ought not be the rationing factor. I hope to be able to do what Jim Bob already has done — keep the commission focused on fairness so physicians can continue to provide care in the same type of system we have now without having to go to a Canadian-type system."

The Centerville family physician was nominated for the PPRC by the Texas Medical Association, with support from the American Medical Association. The appointment was announced February 24 by the Office of Technology Assessment of the US Department of Health and Human Services.

Dr McKinney was first elected to the Texas House in 1984. During his tenure, he served on the House Committees on Appropriations and Environmental Affairs, as well as the House Calendars Committee, which schedules legislation for floor debate. In 1989 he sponsored several major health-related bills that were enacted into law, including the Omnibus Health Care Rescue Act, Omnibus AIDS Bill, and the mandatory motorcycle helmet use law.

TMA member appointed to nursing home panel

AUSTIN PHYSICIAN AND Texas Medical Association member Peggy Russell, DO, has been appointed to an advisory group that will help lawmakers examine complaints of substandard nursing home care.

Dr Russell, a member of the TMA Committee on Aging and Long-Term Care, was among 10 people appointed to the Work Group on Nursing Homes. The work group was created by the Legislative Health and Human Services Board following release of a report that up to one third of Texas nursing homes have a history of violating health and safety rules. Other members of the committee include a pharmacist, nurse, nursing home operators, and consumer advocates.

"There is an overall sense that there are serious violations in the delivery of care in nursing homes, but it is not well pinpointed or substantiated," said Dr Russell, who treats nursing home patients in her practice. "The people on the committee represent all facets of interest in nursing home care and have been brought together to look at the issues."

The Texas nursing home industry has come in for harsh criticism from Gov Ann Richards and others since the release of the report citing numerous violations.

Laura Smith, special assistant for research and policy development in House Speaker Gib Lewis' office, said the work group probably will look at which agencies should have authority over licensing and investigating nursing homes.

Under legislation passed in 1991 to restructure health and human services agencies, authority to license nursing homes was transferred from the Texas Department of Health to the Texas Department of Human Services, which already had authority to set nursing home rates. Authority for investigating complaints of abuse and neglect was transferred to a newly created Department of Protective and Regulatory Services. It has been suggested, Ms Smith said, that licensing authority also should be given to the new agency.

The work group also has been asked to develop a mission statement for nursing home regulation and to review proposed regulations on penalties and sanctions. ★

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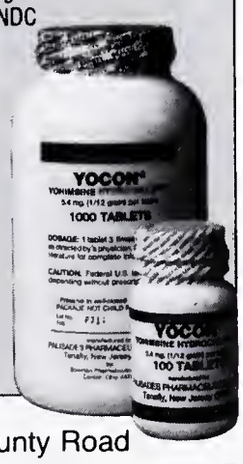

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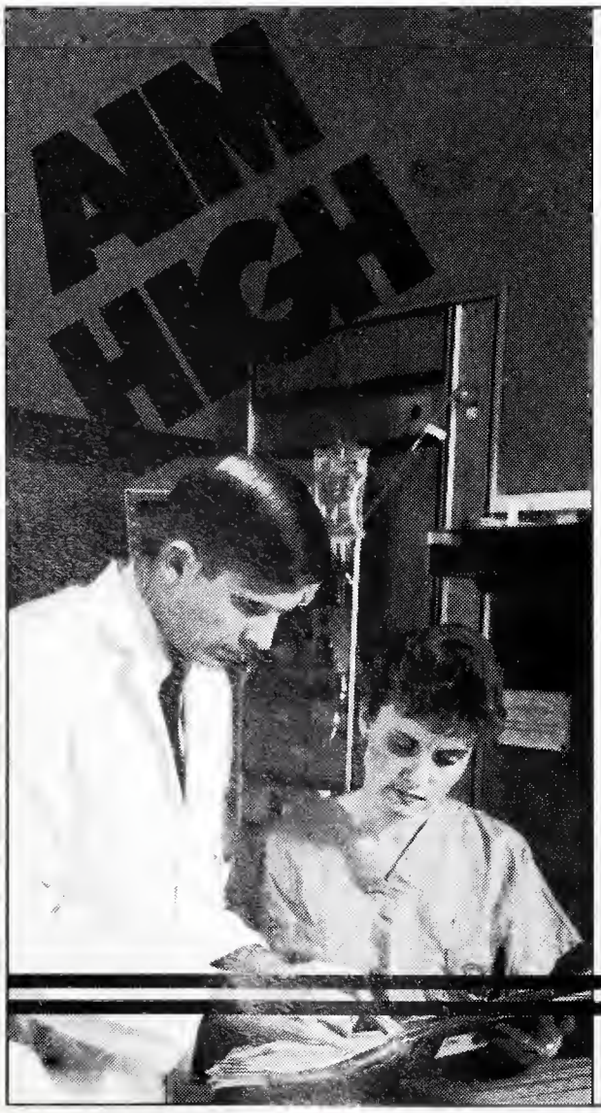

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

Neonatal transport in Texas

Joseph B. Zwischenberger, MD
Susan Keeney, MD
Glen Raymond, BA
Melissa Hanson, BA
Charles S. Cox, Jr, MD

The critically ill newborn requires specialized care, which is generally provided in neonatal intensive care units (NICUs). We surveyed all identifiable NICUs in the state of Texas to study deficiencies in the current system. Despite the existence of many neonatal transport teams, little or nothing has been done to coordinate similar efforts at different programs or to organize programs into sharing the responsibility of transport among the less served areas of Texas. The lack of adequate reimbursement may be a limiting factor in the organization and regionalization of neonatal transport. We urge further efforts toward coordination and regionalization of transport with an examination of reimbursement policies to allow teams to share equally the responsibility of neonatal transport in Texas.

Dr Zwischenberger, associate professor, Division of Cardiothoracic Surgery; Dr Keeney, assistant professor, Department of Pediatrics; Mr Raymond and Ms Hanson, medical students; and Dr Cox, surgical research fellow, The University of Texas Medical Branch at Galveston. Send reprint requests to Dr Zwischenberger, Room 6.120, John Sealy Building, Galveston, TX 77550.

The critically ill newborn requires the specialized care that is generally provided in neonatal intensive care units (NICUs). Limitations of resources have necessitated regionalization of neonatal intensive care to tertiary referral centers. Compared to neonatal transfer, antenatal referral of the high-risk fetus to a tertiary center is associated with improved survival (1–3), but because antenatal referral is not always possible, the critically ill neonate must often be transported after birth. Neonatal transport systems employing properly trained personnel and specialized equipment have been shown to improve neonatal mortality (4, 5).

Texas has numerous NICUs, but little data are available concerning the transport systems of these units. The stimulus for this study was the organization of transport among the extracorporeal membrane oxygenation (ECMO) programs in Texas, which are located in Lubbock, San Antonio, Dallas, and Galveston (6). For the provision of adequate ECMO availability in Texas, neonates must be transported to these centers from all areas of the state. We surveyed all identifiable NICUs in the state of Texas to examine the transport facilities, usage, needs, and perceived deficiencies of the current system.

METHODS

We mailed a survey to the medical directors of all NICUs in the state of Texas identified in the *1987 Annual Survey of Hospitals* by the Texas Department of Health (7). A neonatal intensive care unit, as defined by the Texas Department of Health, is "a unit that must be separate from the newborn nursery providing intensive care to all sick infants including those in the very lowest bir weights (less than 1500 grams). T NICU has potential for providi mechanical ventilation, neonat surgery, and specialty care for t sickest infants born in hospital transferred from another institutio A full-time neonatologist serves director of the NICU." NICUs we identified in the annual survey self-reporting in accordance wi these guidelines.

Because we proposed to surv those hospitals that provide t most highly specialized neonatal i tensive care and that receive most the transported neonates, we defin arbitrarily criteria for a tertia NICU. These criteria included se reporting as a level III NICU, a fu time neonatologist serving as dire tor of the unit, and provision mechanical ventilation for mo than 48 hours. The survey address acceptance of patients born in oth hospitals, availability and modes transport to the NICU geograph service area, and staffing of t transport system. Other questio covered the issue of provision third-party transports, defined transport of a neonate from o hospital to a second hospital provi ed by a third hospital. Methods reimbursement for primary an third-party transports were a dressed also. The final portion of t survey asked for the perceived ad quacy of neonatal transport in Tex to be rated on a scale of 1 through (1 = poor, grossly inadequate; 5 good, adequate). Responders we asked also to list perceived inad quacies and suggestions for impro ing the neonatal transport system Texas. Responders were responsib for the accuracy of the data report in the survey.

SULTS

r the 54 NICUs surveyed, there re 53 responders (98%). Thirty-e of the 53 fulfilled our criteria for tertiary NICU. Of the 32 of these its that accept patients born in oth- hospitals, 25 (78%) provide trans- rt to their own units. These 25 its form the data base of this re- rt. We have classified Dallas Coun- Hospital District and Children's ospital of Dallas as one unit that ovides transport. Eighteen of the 25 its stated that they provide exclu- ely their own transport, whereas 6 so receive patients born in other spitals transported by other teams referring physicians. Only seven rtiary NICUs that accept patients rn in other hospitals do not pro- de their own transport.

Table 1 summarizes characteris- s of the 25 transport systems op- ated by tertiary NICUs. Major xas cities with available transport ams include the Dallas/Fort Worth ea (n=7), Houston (n=4), San An- nio (n=2), Odessa (n=3), and Lub- ck (n=2). Corpus Christi, Austin, Paso, Harlingen, Amarillo, Galve- on, and Temple each have one ansport team. The number of in- nsive care beds in each of these nters is shown in Table 1. Fig 1 emonstrates the self-perceived nge of transports provided by ese teams. Many teams with fixed- ing (airplane) capability consid- ed their range "unlimited."

All teams have the capacity for mbulance transport. In all centers cept Fort Worth and Galveston, ore than 50% of transports were y ground ambulance. Twelve of the 5 teams (48%) transport by heli- opter in selected cases and 16 54%) have the capacity for fixed- ing (airplane) transport. Seven centers performed 0 to 50 transports per year, four transported 50 to 100 patients per year, and 12 centers performed more than 100 transports per year. Information concerning volume of transports was unavailable for two centers.

Only 11 transport teams (44%) provided third-party transport between two other hospitals. Certain cities and areas were identified in which transport appears to be more clearly organized, and one hospital provides most of the transport for that area. Examples include Seton Hospital in Austin and Santa Rosa Hospital in San Antonio. In addition, several of the teams in the Dallas/Fort Worth area may provide third-party transport. In other areas, no teams were identified as providing third-party transport (eg, Houston).

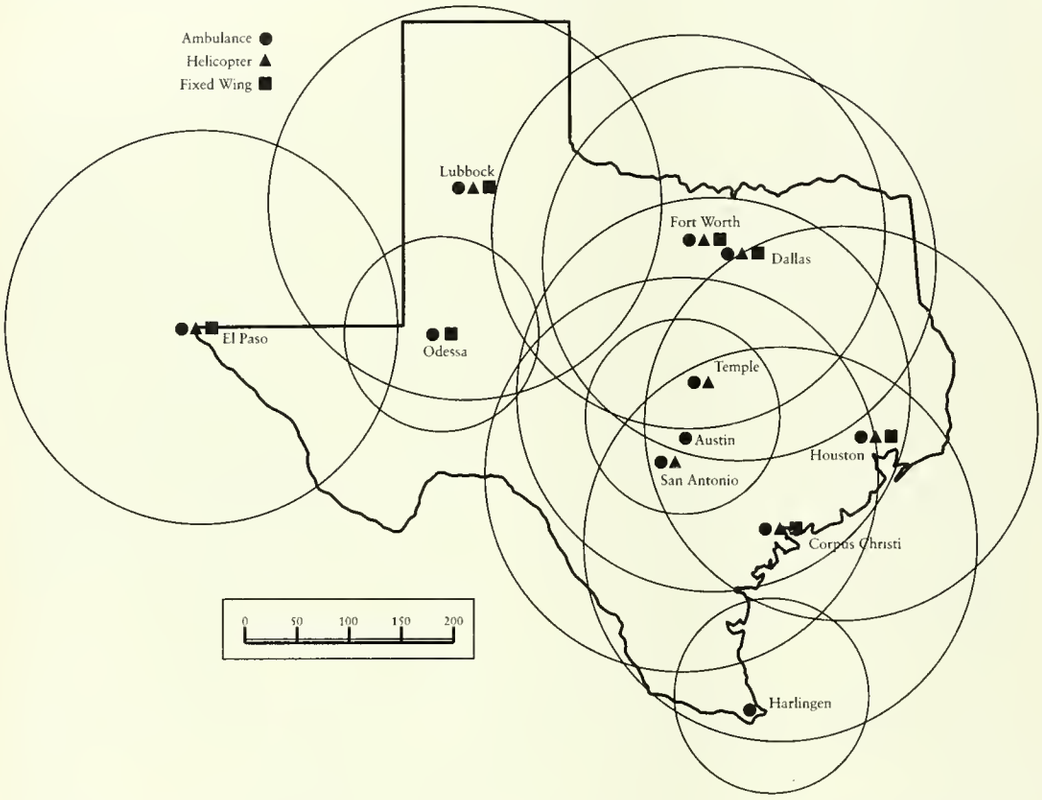
All centers responded that nurses were involved in transport and all but one team included a respiratory therapist. In 18 centers (72%), a specially trained neonatal transport nurse was involved. Staff nurses transported for 10 centers, with 3 centers employing both specially trained transport nurses and staff nurses. Pediatric residents transported neonates in three centers. Five centers responded that a physician other than a pediatric resident accompanied the transport team in selected cases. Six additional centers listed without qualifications a physician accompanying transports, so we assumed that a physician accompanied all transports. Eleven centers (44%) responded that a physician did not accompany the transport team.

Table 1. Demographics of transport teams in Texas.

City	No. of NICU Beds	No. of Transports Per Year	Vehicle	Third Party
Galveston	10	60	A, H, FW	Yes
Corpus Christi	35	415	A, H, FW	No
Harlingen	20	75	A	No
Amarillo	18	NA	A, FW	Yes
Lubbock	10	NA	A, H, FW	No
Lubbock	35	95	A, H, FW	No
El Paso	14	40	A, H, FW	Yes
Odessa	16	20	A, H	No
Odessa	16	33	A, FW	No
Odessa	10	30	A, FW	No
Temple	21	120	A, H	No
Fort Worth	40	900	A, H, FW	Yes
Fort Worth	30	1,000	A, H, FW	Yes
Houston	12	140	A	No
Houston	12	178	A, H, FW	No
Houston	22	300	A	No
Houston	10	35	A	No
Dallas	18	32	A, FW	Yes
Dallas	38	86	A, FW	No
Dallas	32	240	A, FW	Yes
Dallas	32	150	A, H, FW	Yes
Dallas	40	545	A, FW	Yes
San Antonio	15	200	A, H	Yes
San Antonio	23	30	A, H	No
Austin	26	150	A	Yes

A = Ambulance; H = Helicopter; FW =Fixed Wing

Fig 1. Newborn intensive care units with transport capability in Texas. Circles represent the range of transport of each center with multiple areas of overlap.



Twenty of the 25 centers responded to the survey question concerning methods of reimbursement, specifically by private insurance, Medicaid, or none. All but two of these centers transported patients of all three pay classes, with the remaining two only transporting patients with insurance or Medicaid reimbursement. Eleven of the 20 respondents stated that more than 50% of their transports were reimbursed by private insurance.

The survey requested a rating of the adequacy of neonatal transport in the state of Texas on a scale of 1 through 5 (1 = poor, grossly inadequate; 5 = good, adequate). Seven centers did not respond with a specific rating. The remaining centers responded as follows: rating of *1* (2 centers), rating of *2* (6 centers), rating of *3* (5 centers), rating of *4* (2 centers), and rating of *5* (3 centers). When asked what the major inadequacies of neonatal transport in Texas were, 12 centers listed the need for a state-supported and organized transport system, and 10 centers stated that reimbursement for transport of indigent patients was needed. Several centers stated that the expense of long-distance transport of indigent patients without reimbursement is difficult for many smaller institutions to absorb.

DISCUSSION

We have found 25 identifiable neonatal transport teams operating in the state of Texas. These teams have been designed to suit the catchment areas of their particular institutions. The composition of the transport teams is notable in that transport of neonates in Texas is conducted p marily by specialized neonatal trai port nurses. Reports of transport se vices in other states describe simil staffing composition (4,5,7,8). Th role encompasses many functio usually thought to be physician rela ed, including assessment of the cri cally ill patient, intubation and ma agement of mechanical ventilatio and performance of other invasi procedures. The issues of the trainin of these nurses and their staffing rol in the NICU were not addressed our survey.

Eleven of the 25 transport tear (44%) are located in the Houston Dallas/Fort Worth metropolitan a eas, with 14 teams providing servi for the remaining geographic are The range of the existing transpo teams suggests that they can ad quately cover the transport neonates in the state. However, majority (65%) of responding mec cal directors of the NICUs operatin these transport teams perceive th the neonatal transport system Texas is less than adequate (rating 3 or less). This suggests that not a infants in Texas are receiving opt mal access to a tertiary NICU.

We do not have data explainin the precise reasons behind the r sponse that a state-organized syste is needed. However, it is clear th services overlap, that they are expe sive to maintain and operate, ar that some areas are underserved; v postulate that these are the reaso why some are calling for an org nized system. The responde specified the lack of regionalizatic as the greatest limitation of th transport system in Texas. We ca identify several factors justifying th need for regionalization. First, on 44% of the transport teams reporte that they perform third-party tran

orts. We identified seven NICUs at accept patients born in other ospitals but have no transport ams. These units, in addition to e other level II units that accept atients born in other hospitals, ould be expected to receive pa-ents either by third-party trans-orts from an organized team or by ferring physicians. Unfortunately, ansport by referring physicians is ften uncoordinated and performed y inexperienced teams. Second, exas comprises wide geographic istances. Many transport teams do ot have the capacity to provide apid service over great distances, hich usually requires air transport ther by helicopter or fixed-wing ehicles. Helicopter availability usu-lly involves on-site maintenance of helicopter and a pilot, making this much more expensive mode than mbulance transport. Fixed-wing ansport often requires contracting ith a charter company for pay-ent. Regionalization would pro-ide more effective use of these ex-ensive services. Third, the labor nd expense of supporting specially ained personnel for neonatal trans-ort with adequate transport vol-me to maintain their skills is an ad-itional resource that would not ave to be reproduced by all NICUs regionalization existed.

The lack of adequate reimburse-ent may well be a limiting factor in he provision of neonatal transport nd, in particular, organization and egionalization of transport. Main-aining a trained transport team and roviding specialized transport vehi-les (eg, helicopter) constitute an ex-ensive venture. Many of the trans-ort teams specifically stated that eimbursement, particularly for wide eographic distances, is sorely needed.

In summary, a number of neonatal transport teams exist in the state of Texas. However, little or nothing has been done to coordinate similar efforts at different programs or to organize programs into sharing the responsibility of transport among the more distant or lesser served areas in the state of Texas. The areas in western and southwestern Texas do not appear to be adequately served. Some of these regions are at least 150 miles from the nearest NICU and are covered only by air transport. Likewise, with no reliable reimbursement policies, teams may be reluctant to transport nonpaying patients or to travel great distances to provide transportation. We urge further efforts toward coordination and regionalization among these teams, and we have identified a strong need for reimbursement policies to allow the teams to share equally in the responsibility of the transport of neonates in the state of Texas.

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Laser-assisted angioplasty: an intervention and backup system for catheterization laboratories conducting angioplasty

A. Tomas Garcia, MD

This article reports preliminary results of laser-assisted angioplasty intervention. Early results indicate successful intervention in peripheral arteries.

Since the previous publication in *Texas Medicine* (1), other publications (2–6) have verified the effectiveness of the Lastec System in total obstructions of peripheral arteries. From October 1988 to January 1990, the catheterization laboratory at Sam Houston Memorial Hospital, Houston, Tex, has received 23 patients for laser-assisted angioplasty. Thirteen males and 10 females ranging from ages 54 to 79 years were selected for this procedure. Of these 23 patients, an occasional patient had multiple procedures.

RESULTS

Three (13%) iliac arteries, 18 (68%) superficial femoral arteries, 1 (4%) popliteal artery, and 3 (14%) tibial arteries were subjected to laser-assisted angioplasty. No patients died as a result of the procedure. The only complication occurred in a patient with a perforation of the iliac artery. The specific site of perforation was not identified at the time of surgery. In another patient, lack of anatomical recognition permitted the lasing and dilation of a partially obstructed femoral vein. Nonetheless, this patient became asymptomatic after the procedure.

Success was determined primarily by measuring the ankle-brachial index (ABI). An overall improvement was seen from the pretreatment value of 0.6 ABI to the posttreatment value of 0.8 ABI. Also success was defined as angiographic improvement in the blood flow through an artery that had been totally obstructed. Clinical improvement, the ability to walk more than two blocks, occurred in 80% of the cases.

Of totally obstructed lesions in arteries, we noted an 80% success rate. These results are consistent with other reported rates of succes Of the 23 patients, 18 experience significant clinical improvement an were pleased to have avoided th open method of surgery.

Recanalization was successful i greater than 80% of the superficia femoral arteries and greater tha 60% in iliac arteries. These result are also consistent with reporte rates (2). Of particular interest is case of a calcium deposit, which al though not absorbed by the argo wavelength energy, does not pre clude the possibility of success.

DISCUSSION

The results in the iliac and tibial ar teries were slightly less successfu than those in the superficial femora artery. A prospective study to com pare these vessels is now in progress

The series reported here demon strates that the system effects clinica improvement in 80% of cases of to tally obstructed arteries. The lov morbidity is enhanced by the coaxia alignment of the free laser fiber, th optical divergence of the argon ener gy, and the control the physician ha in delivering the energy by the sys tem. By having this system in th catheterization laboratory, the cardi ologist can treat more aggressivel patients who were previously poo surgical candidates. Having the lase equipment in the catheterization lab oratory gives the physician an adde dimension in approaching othe problems, such as reoccluding arter ies following secondary dissectio after angioplasty (7). With the ad vent of more sophisticated catheter (8) on the horizon, the future for ag gressive cardiovascular intervention is indeed optimistic.

Send reprint requests to Dr Garcia, Houston Heart Centre, 9034 Westheimer, Suite 425, Houston, TX 77063.

KNOWLEDGMENT

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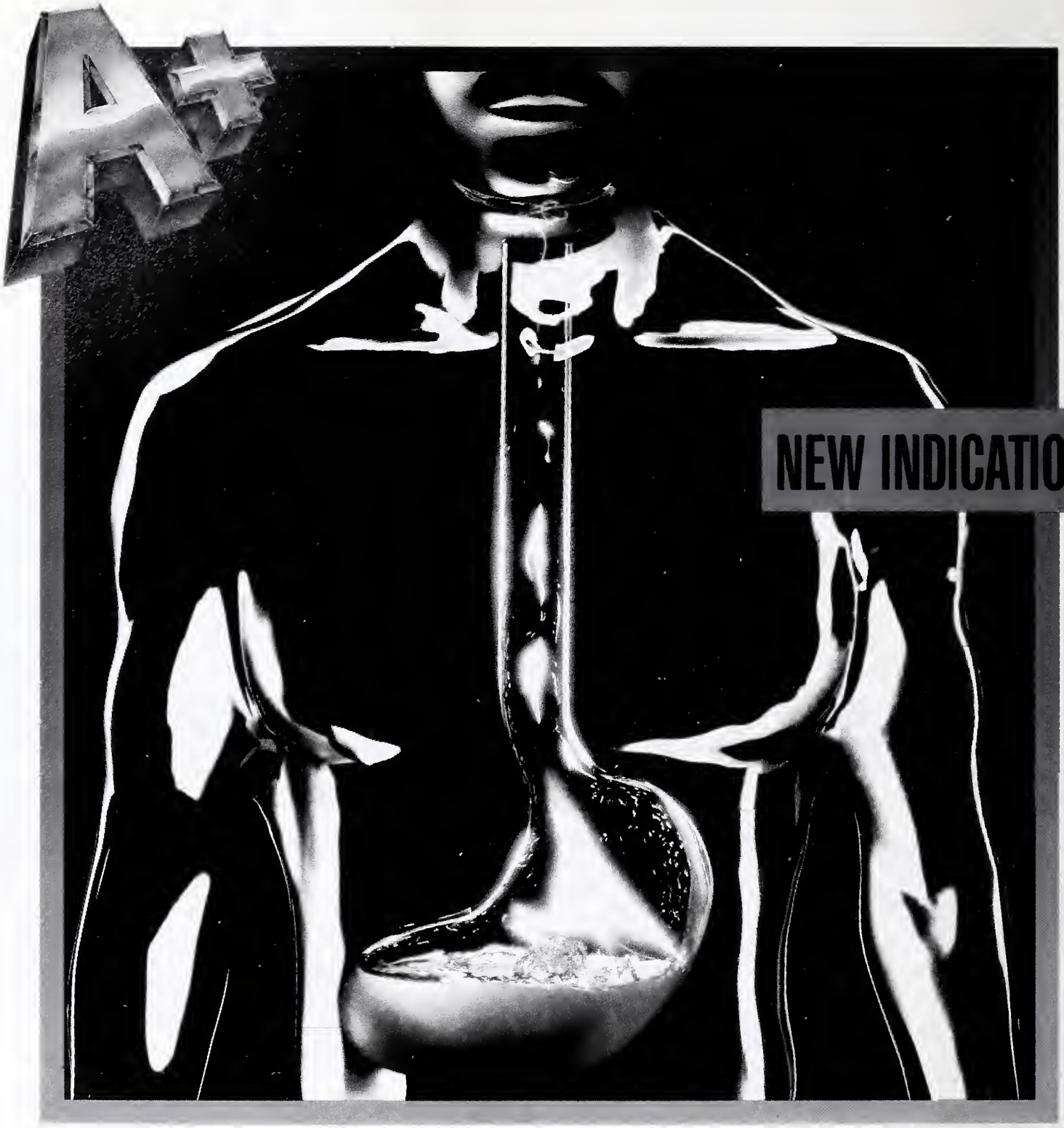

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity baffery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizahdine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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Urologist

CORPUS CHRISTI
Family Physician
Nephrologist
OB/GYN
Pediatrician

DALLAS AREA
Family Physician

Call **1-800-626-1590, ext. 153** should you wish to investigate any of these opportunities. Or send your CV to Gordon Crawford, Manager, Professional Relations, Humana Inc., Dept. TX4-2D, P.O. Box 1438, Louisville, KY 40201-1438.

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Position Available — Seeking BC/BE Family Practice, General Internist, Endocrinologist, OB/GYN to join established multi-specialty clinic. Excellent benefits and guarantee. Send CV to Leroy W. Kitch, Administrator, Skinner Clinic, 124 Dallas St., San Antonio, TX 78205.

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Vanderbilt University TXM
PO Box 1736-B
Nashville TN 37235-0001
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FAX: 1-615-322-3365

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- Joseph W. Synan, M.D., leadership consultant
- Steve Booton, M.D., physician-patient communication consultant

What's In, What's Out in Medicare... Discussion With the Experts

Find the latest on RBRVS and improving third-party reimbursement

- Angela Vierville, medical reporter, KSAT-TV, SanAntonio
- J. Michael Hudson, Deputy Administrator, Health Care Financing Administration
- Harold Whittington, medical practice consultant

TexasMedical Association

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Includes two appendices:

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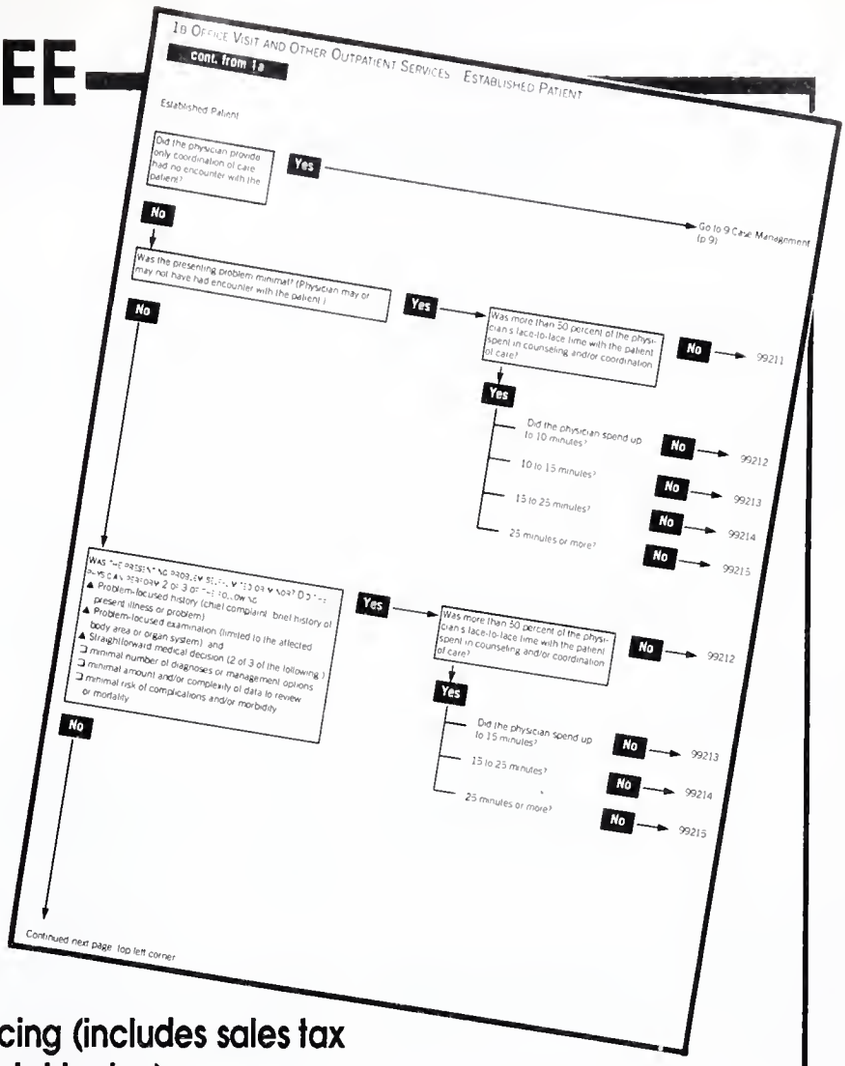

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Texas Medical Association

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CME / Continuing Education Directory

Courses

MAY

Cardiology

May 13–15, 1992
Clinical Auscultation of the Heart. Washington, DC. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Family Medicine

May 18–22, 1992
Review Course in Family Medicine. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

General Medicine

May 9, 1992
Cardiac Arrhythmias. Dallas. Contact St Paul Medical Center, Office of CME, 5909 Harry Hines Blvd, Dallas, TX 75235 (214) 879-3789

May 20–23, 1992
Controversies in Women's Health Care. Acapulco, Mexico. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Internal Medicine

May 28–29, 1992
Update in Primary Care Internal Medicine. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Ophthalmology

May 16–17, 1992
Ophthalmic Practice Management Symposium. San Antonio. Contact Texas Ophthalmological Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1504

Pathology

May 14–16, 1992
Current Issues in Surgical Pathology. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

May 16, 1992
Fine Needle Aspiration Basic Tutorial. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

May 21–22, 1992
Current Issues in Anatomic Pathology. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

May 1–2, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

May 14–16, 1992
Advances & Controversies in Clinical Pediatrics. San Francisco. Contact Extended Programs, Rm LS-105, University of California School of Medicine, San Francisco, CA (415) 476-4251

Risk Management

May 14, 1992
Grand Rounds in Medical Malpractice. Dallas. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

May 16–17, 1992
Grand Rounds in Medical Malpractice. Dallas. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

May 19, 1992
Grand Rounds in Medical Malpractice. McAllen. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

May 21, 1992
From Deposition to Courtroom. Dallas. Contact Texas Medical Association Risk Management Office, 401 W 15th St, Austin, TX 78701 (512) 370-1411

Surgery, Oral & Maxillofacial

May 2–3, 1992
Office Anesthesia. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

JUNE

Cardiology

June 3–6, 1992
Advanced Echocardiography and Dopp Ultrasound. San Diego. Contact Americ College of Cardiology, Extramural Pr grams, PO Box 79231, Baltimore, M 21279-0231 (800) 257-4739

Emergency Medicine

June 10–11, 1992
Emergency Care Update. Arlington. Co tact CareFlite Fort Worth, 1301 Pennsylv nia Ave, Fort Worth, TX 76104 (817) 88 4010 or (800) 772-5840

Endoscopy

June 19–20, 1992
Colonoscopy and Colonoscopic Polypect my. New Orleans. Contact Conferenc Ltd, 211 E 18th St, New York, NY 100 (212) 673-8927

June 24–25, 1992
Colonoscopy and Colonoscopic Polypect my. Portland, Me. Contact Conferenc Ltd, 211 E 18th St, New York, NY 100 (212) 673-8927

June 26–27, 1992
Colonoscopy and Colonoscopic Polypect my. Seattle. Contact Conferences Ltd, 2 E 18th St, New York, NY 10003 (21 673-8927

Neurology

June 19–20, 1992
Epilepsy: The Next Generation. Lubboc Contact Office of CME, Texas Tech Ui versity Health Sciences Center, Lubboc TX 79430 (806) 743-2929

Obstetrics and Gynecology

June 14–17
Ob-Gyn Seminar. South Padre Islan Contact Office of CME, Texas Tech Ui versity Health Sciences Center, Lubboc TX 79430 (806) 743-2929

June 18–19, 1992
Diagnosis & Management of Lower Gen tal Tract Neoplasia. Contact The Univers ty of Texas Southwestern Medical Cent Office of CME, 5323 Harry Hines Blv Dallas, TX 75235 (214) 688-2166

ology

ıe 19–20, 1992
ıcheoesophageal Puncture: Voice storation After Total Laryngectomy. uston. Contact The University of Texas D. Anderson Cancer Center, Conference vices, Box 131, 1515 Holcombe Blvd, uston, TX 77030 (713) 792-2222

hthalmology

ıe 11–13, 1992
rnea & Contact Lens Seminar. St Louis. ntact Washington University School of dicine, Office of CME, 660 S Euclid Ave, Louis, MO 63110-1093 (800) 325-9862

thopedic Surgery

ıe 5–7, 1992
thopaedic Surgery Review. Dallas. Con- t The University of Texas Southwestern edical Center, Office of CME, 5323 Har- Hines Blvd, Dallas, TX 75235 (214) 8-2166

olaryngology

ne 11–13, 1992
olaryngology Update. Galveston. Con- ct Office of CME, The University of xas Medical Branch, Rte J-34, Shearn oody Plaza, Galveston, TX 77550 (409) 2-7834

diatrics

ne 15–19, 1992
ute Care Pediatrics Review & Update. lton Head, SC. Contact Baylor College of edicine, Office of CME, One Baylor aza, Houston, TX 77030 (713) 798-6020

ne 18–20, 1992
diatric Review & Update. Galveston. ontact Office of CME, The University of xas Medical Branch, Rte J-34, Shearn oody Plaza, Galveston, TX 77550 (409) 72-7834

astic Surgery

ne 4–7, 1992
dvances in Aesthetic & Reconstructive reast Surgery. St Louis. Contact Washing- n University School of Medicine, Office CME, 660 S Euclid Ave, St Louis, MO 3110-1093 (800) 325-9862

rology

ıne 26–28, 1992
rontiers in Endourology: Laparoscopic Nephrectomy & Beyond. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

JULY

General Medicine

July 2–4, 1992
Highlights in Women's Health Care. Santa Fe, NM. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

July 17–19, 1992
Caring for the Aging Population: Knowledge & Skills for the Primary Care Physician. San Francisco. Contact American Geriatrics Society, 770 Lexington Ave, Ste 300, New York, NY 10021 (212) 308-1414

Obstetrics and Gynecology

July 11–13, 1992
Issues in Care: Ob-Gyn. South Padre Island. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

July 27–29, 1992
Ob-Gyn Summer Seminar. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Ophthalmology

July 24–25, 1992
PHACO 1992. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

AUGUST

Allergy

Aug 6–8, 1992
Clinical Allergy for the Practicing Physician. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Family Medicine

Aug 6–9, 1992
Family Medicine Update. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Pathology

Aug 9–15, 1992
Fine Needle Biopsy Course. Mauna Lani, Hawaii. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

SEPTEMBER

Dermatology

Sept 11–12, 1992
Wound Care. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Ophthalmology

Sept 10–13, 1992
Uveitis & Retinal Frontiers. Carmel, Calif. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

Sept 18–19, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Psychiatry

Sept 24–27, 1992
Multiplicity of Approaches to Treatment of Multiple Personality Disorder. Austin. Contact Don Young, Shoal Creek Hospital, 3501 Mills Ave, Austin, TX 78731 (512) 452-0361

OCTOBER

Dermatology

Oct 17–18, 1992
The Skin from A to Z. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Oncology

Oct 10–13, 1992
Pharmacy Symposium on Cancer Chemotherapy. Houston. Contact The University of Texas M.D. Anderson Cancer

Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Oct 17–23, 1992
Symposium on Fundamental Cancer Research. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Oct 20–23, 1992
Immunobiology of Cancer Research Symposium: Molecular and Cellular Mechanisms. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

NOVEMBER

General Medicine

Nov 21, 1992
Hyperlipidemia Seminar. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Oncology

Nov 6–10, 1992
International Symposium on Polyamines in Cancer. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Otolaryngology

Nov 5–7, 1992
Otolaryngology Update. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

Nov 5, 1992
Pediatric Advanced Life Support Renewal Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Nov 6–7, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Psychiatry

Nov 13–15, 1992
Group Therapy Symposium. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

DECEMBER

Ophthalmology

Dec 10–11, 1992
Glaucoma Management. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

TMA Risk Management Seminars

The following course is sponsored by the Texas Medical Association through its Practice Management Department. All seminars, unless otherwise announced, will be held from 7 pm–10 pm. For further information, contact the TMA Risk Management Office, 401 W 15th St, Austin, TX 78701 (512) 370-1411.

Apr–Nov, 1992

From Deposition to Courtroom
Apr 23, Dallas
May 21, San Antonio
Jun 11, Houston
Aug 27, Houston
Sept 19, Austin (during TMA Fall Leadership Conference)
Oct 22, Dallas
Nov 19, San Antonio

Calendar of Meetings

•Denotes Texas meeting

April

Apr 2–4, 1992, San Antonio
•*Texas Urological Society Annual Meeting*
Contact TUS, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1526

Apr 2–5, 1992, Houston
•*Texas Radiological Society Annual Meeting*
Contact TRS, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1507

May

May 14–17, 1992, San Antonio
•Texas Medical Association Annual Session
Contact TMA, 401 W 15th St, Austin, T 78701 (800) 880-1300 or (512) 370-145(

May 16–17, 1992, San Antonio
•*Texas Society of Anesthesiologists Inte im Meeting*
Contact TSA, 401 W 15th St, Ste 99(Austin, TX 78701 (512) 370-1659

June

June 18–20, 1992, Austin
•Texas Medical Association 1992 CME Conference (for Planners and Sponsors of CME)
Contact TMA, 401 W 15th St, Austin, T 78701 (800) 880-1300, Ext 1446 or (51 370-1446

September

Sept 11–13, 1992, El Paso
•*Texas Society of Anesthesiologists Annu al Meeting*
Contact TSA, 401 W 15th St, Ste 99(Austin, TX 78701 (512) 370-1659

Sept 19, 1992, Austin
•Texas Medical Association Fall Leadership Conference
Contact Jon Hornaday, 401 W 15th S Austin, TX 78701 (800) 880-1300 o (512) 370-1345

Sept 27–30, 1992, Houston
•*Texas Technology Transfer Association*
Contact The University of Texas M.D. An derson Cancer Center, Conference Services Box 131, 1515 Holcombe Blvd, Houston TX 77030 (713) 792-2222

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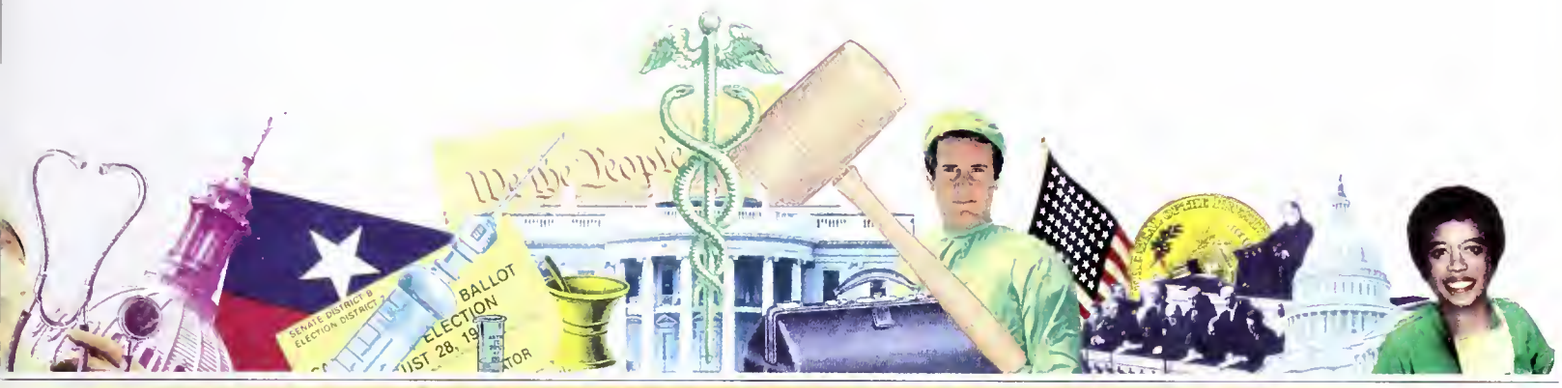

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Cover illustration by Melissa Grimes.

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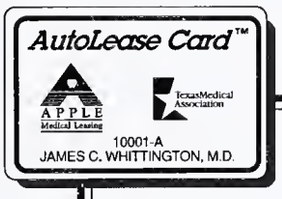

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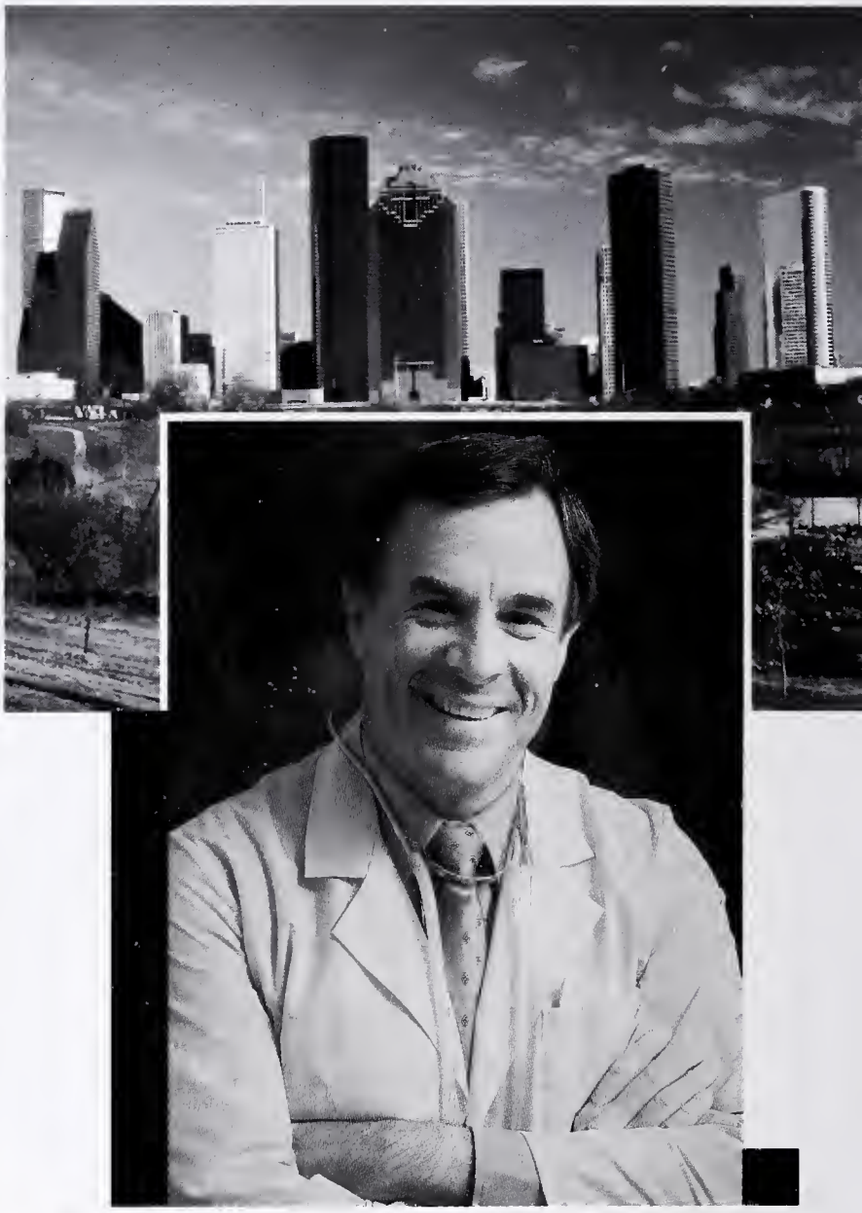

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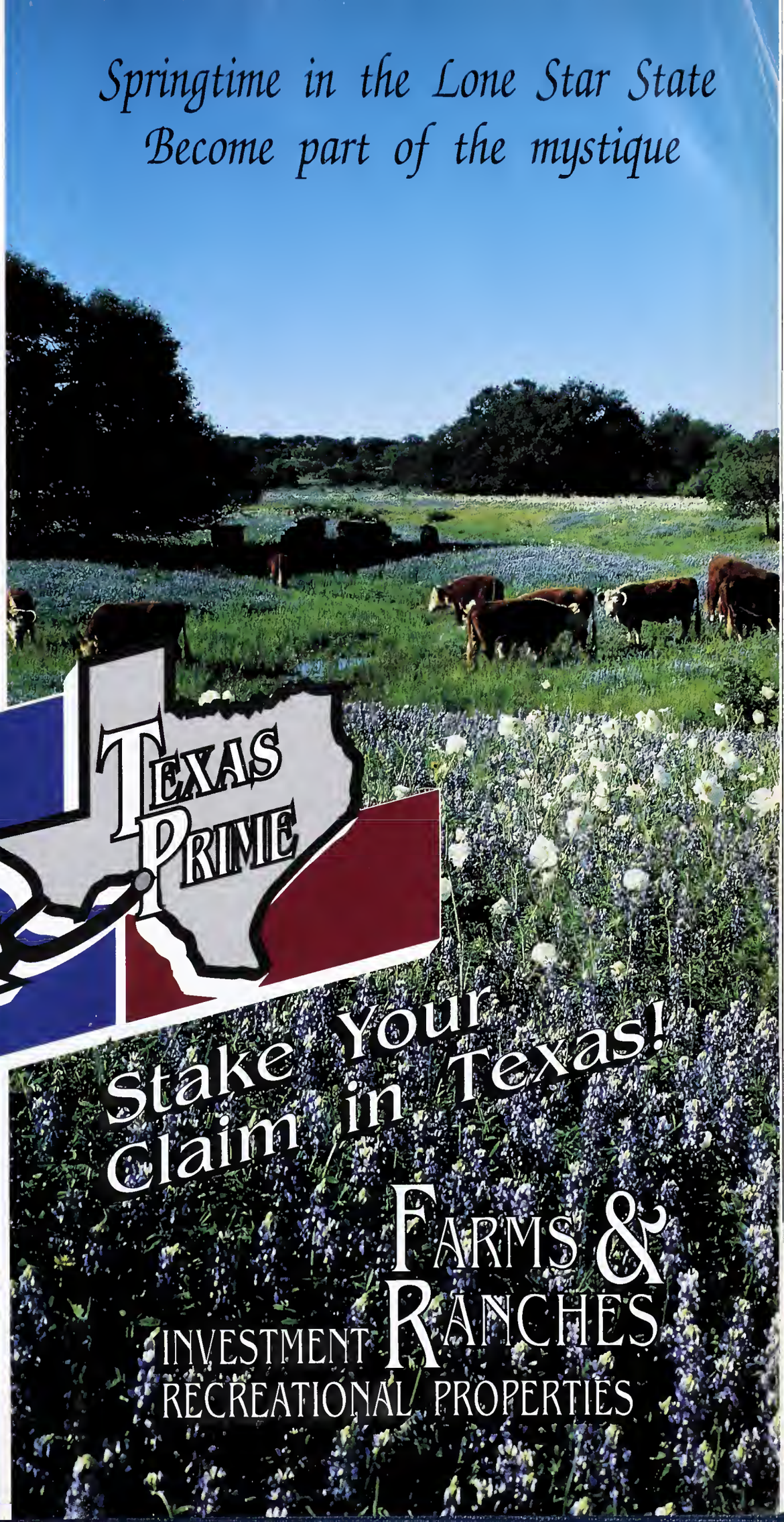

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Letters

Avoiding confusion about the word "narcotic"

"When I use a word," Humpty Dumpty said in rather a scornful one, "it means just what I choose it to mean — neither more nor less."
— LEWIS CARROLL,
Through the Looking Glass.

I WRITE TO COMPLIMENT C. Stratton Hill, Jr, MD, on his scholarly presentation of the roblem of severe pain and the ifficulties encountered by physicians ho prescribe doses of analgesic rugs that are adequate for relief (1).

I have always been interested in ends in society that have an impact n the practice of medicine. My curent interest is the word "narcotic." Most physicians define "narcotic" as ny agent that causes insensibility or upor, applied especially to any natral or synthetic drug that has opim-like action. The word evokes no motional response in most physians. However, the meaning of the ord in the public domain has asumed more profound significance han we realize. The television comercials that portray eggs frying in a an accompanied by the statement, This is your brain on drugs," have ad their effect. We now have narotic addicts, narcotic traffic, narotic agents, narcotic police, and arcotic dealers. We even have a war against narcotics," and we ust be careful not to be perceived o be on the wrong side of this war.

If I tell patients that a narcotic vill be an important part of their nesthetic, I know that I have volunteered for a lengthy discussion of the ifference between legitimate medial uses of drugs and the immoral or nlawful uses of those same drugs. Even after detailed explanations, I sense that the patient feels that I am using my sacred medical license intentionally to expose them to evil. I have taken the easy route; I never say the word "narcotic" to a patient. I substitute "opioid."

The Pharmacological Basis of Therapeutics states, "the term narcotic was obsolete long before the discovery of endogenous opioid-like ligands and receptors for these substances. . . . With the increasing use of the term in a legal context to refer to any substance that can cause dependence, the term narcotic is no longer useful in a pharmacological context" (2).

The meaning of the word "narcotic" has changed completely in a brief period of time. We must recognize and respond to the new meaning. I urge you to substitute the word "opioid" for all legitimate medical uses, and to reserve "narcotic" for all unlawful, immoral, and evil uses. This simple substitution of words will guarantee that physicians who relieve pain are on the correct side of the "war against narcotics."

A.H. Giesecke, MD
Jenkins Professor and Chairman
Department of Anesthesiology
The University of Texas
Southwestern Medical Center
5323 Harry Hines Blvd
Dallas, TX 75235-9068.

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Dangers of the occult must be acknowledged

IT WAS WITH GREAT SADNESS that I read Dr Gorski's letter (*Texas Medicine*, February 1992, p 7), attempting to trivialize satanism and its effects on those involved in it. The supernatural is, by its very nature, something not subject to experimental verification. However, satanic influence in various crimes and occultic involvement of some of the most evil men in history (Hitler, et al) is readily verifiable and has been documented. Presumably, the "entertaining" satanic bible he encouraged troubled adolescents to read supports the satanic view of life espoused elsewhere by its author, A.S. LaVey. His beliefs stress "indulgence instead of abstinence," "vengeance instead of turning the other cheek," and "man as just another animal." If Dr Gorski is encouraging our kids, already beset by a staggering assault of drugs, STDs, and violence, to indulge themselves, seek vengeance, and view others as mere animals, then he must be pleased, indeed, at the course our society is presently pursuing. To deny the dangers of the occult is at best naive and foolish, and at its worst, irresponsible. Whatever else it is, it *isn't* good medicine.

W. Robin Schlaudt, Jr, MD
1276 S Peachtree St
Jasper, TX 75951.

Physicians must help write the prescription for health-care reform

NO ONE COULD DISAGREE that health-care delivery in the United States needs help, but I do not feel there is a "crisis" requiring urgent change. Instead, the federal and state governments should study the situation seriously, involving members of all levels of the health-care system, including rural practicing physicians and users of the system.

The administration plans to provide "universal" access to health care by controlling the Medicare and Medicaid premiums it pays to physicians and hospitals. What this will mean in the "real" world is limited and restricted services. The United States cannot continue to provide the same level of excellent care at lower cost.

If the cost of medical care is to be limited, then services will need to be decreased, and the public should be made aware of this tenet. Some difficult decisions must be made, such as: who gets a heart bypass, transplant or renal dialysis, cataract surgery, or hernia/hemorrhoid surgery? We cannot continue providing these services (and many others) at current levels and still limit costs. Forcing hospitals to provide increasing services to Medicare and Medicaid patients at ever lower reimbursements has caused hundreds of hospitals to close, and thousands are in serious financial trouble.

Health-care professionals would be the first to seek help from the government if Washington bureaucrats could solve our health-care problems. The financial burden of providing health care to the 37 million uninsured is now borne by physicians and hospitals. In 1990, uncompensated services amounted to $15 billion.

To place the federal bureaucracy in charge of fixing this problem is to place our public trust in a system that has failed in the past to provide medical care for a portion of the US population. The only real solution is an investment in advisors to manage our needs and resources. The only experts who can currently fulfill this urgent need are the physicians who work in the trenches every day. Leaving the decision for health care to "pork-barrel" politicians and ivory-tower pseudo-intellectuals and paper-pushers is asking for disaster.

Michael W. McShan, MD, PhD
738 Hwy 259 N
Kilgore, TX 75662.

Retired physicians face barriers

AFTER CONSIDERABLE agonizing, I have bitten the bullet and written the check for $292 for registration of my medical license for 1992. I am retired and during the past year probably have written three or four prescriptions for family and friends. This is certainly a high price to pay for that privilege. The other factor in this decision is the emotional one. It is very difficult after more than 40 years of practice to give up that last evidence of being a physician.

It occurs to me frequently what a waste of talent we have in the retired physician community as a result of legal barriers. We could contribute much to charity clinics were it not for the cost of keeping our license active and paying for liability insurance. Without protection from being sued and a more reasonable registration fee we cannot participate in those areas.

I very willingly gave up my na cotics license because I had no des to write prescriptions for those su stances. Not having a DEA ma that easy. I also terminated liabili insurance, which was a considerab financial drain.

Surely there should be a way correct these problems and make t talents of the retired physicians ava able to those in need. I would expe this unused talent pool to increase more physicians retire earlier due the increasing intervention of gover ment between doctor and patient ar the inadequacy of payment for ca of the elderly and indigent. As yo know, your practice tends to gro old along with you and so a high percentage of your patient popul tion is in the Medicare age group. S the paperwork increases, payme for services decreases, and delay payment increases. Suddenly you b come aware that you are takir home 35 to 40 cents out of a doll earned. The responsibility, lor hours, and night phone calls are sin ply not worth it. Isn't this sad?

Ruth M. Bain, M
35 Woodstone Squa
Austin, TX 7870

Editor's note: TMA's general cou sel has asked the Texas State Boar of Medical Examiners to conside redefining "retired physician" to a low retired physicians to provid charity care services without payin the annual registration fee. The ge eral counsel also notes that phys cians volunteering their service should be aware of the Charitab Immunity and Liability Act and th Good Samaritan Law, which reduc liability exposure in certain case (See "Volunteer Liability," Texa Medicine, *July 1991, pp 58–59.)*

(press your point of view in xas Medicine.

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tate-supplied vaccine ould increase accination rate

R SUZANNE CORRIGAN'S commentary on vaccination (*Texas Medicine*, February 92, p 66) left out the most effective eans to increase the rates of immu- zations. Required vaccines (DPT, PV, HIB, MMR) should be made iversally available by the state.

In our office we have "state" vac- ne that we give without charge to edicaid patients. All other patients her buy our private stock, which is pensive, or we send the majority to ir health department where they re- ive the vaccines for a nominal fee.

In years past we received vaccine om the state and vaccinated all our tients for a nominal fee in the fice. If they came to our office be- use of an injury or even a mild up- r respiratory tract infection and eir immunizations were delin- ent, we would try to make them rrent. We would prefer to deliver utine well care with vaccinations, t this is not always possible. Also, me people who come to our office r well checks leave with good in- ntions of going to the health de- rtment for vaccinations. Instead ey procrastinate or the child be- mes ill, and they end up months years behind.

I suggest that the TMA and Texas ediatric Society lobby for universal vailability of vaccines to increase ur dismal rates of immunizations.

G. Edward Clark, MD
635 Stone Ave
Paris, TX 75460.

Group aims to stop lawsuit abuse

MOST TEXAS PHYSICIANS are all too familiar with the problem of lawsuit abuse in our state. It affects us by skyrocketing liability insurance premiums when insurance is available, it causes us to order extra tests and consults resulting in higher medical costs, and it affects the enjoyment of the practice of medicine. Patients experience decreased accessibility to reasonably priced medical care and, in some cases, no care at all.

Texans Against Lawsuit Abuse, sponsored by the Texas Chamber of Commerce, is a statewide nonpartisan movement attempting to educate citizens about the societal cost of lawsuit abuse. It is not a "lawyer bashing" campaign. Texas physicians should support it wholeheartedly with our finances and efforts.

In Victoria, physician chamber members have asked our local chamber of commerce to take on public education as a local project. A number of other large Texas cities have begun this, and Texans Against Lawsuit Abuse is active in Houston, San Antonio, Fort Worth, Arlington, and Corpus Christi. Dallas physicians in particular are urged to join their local chamber and help rally its support of this timely issue.

Texans Against Lawsuit Abuse can be contacted at the Texas Chamber of Commerce, 900 Congress Ave, Suite 500, Austin, TX 78701-2447; (512) 472-1594.

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TMA-B

Upfront

)r Gamel to become 'MA president at ınnual Session

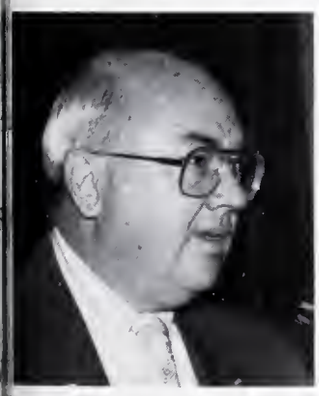
WILLIAM G. GAMEL, MD, Austin, will be installed as TMA president for 1992–993 during the membership lun-ıeon at the 1992 TMA Annual Ses-on in San Antonio. The luncheon is heduled at 12:15 pm on Saturday, ay 16, in the North Banquet Hall the Convention Center.

Dr Gamel, who was chosen TMA esident-elect by the House of Dele-ıtes last May, is a gastroenterolo-st. He served as chairman of the MA Council on Legislation from 986 to 1991, and is an alternate legate to the AMA House of Dele-tes. Dr Gamel is a past president of e Travis County Medical Society.

Also featured during the member-ip luncheon will be "Finding merica," a multimedia presentation out the discovery and development the North America continent.

The luncheon program also in-ıdes presentation of Anson Jones vards to Texas news media and vards for excellence in science to xas teachers.

Tickets for the luncheon ($25) ill be available at the registration ea at Annual Session, which begins ay 14 and runs through May 17.



illiam G. Gamel, MD

Delegates to debate HIV policy and other controversies

MANY OF THE MOST complex and controversial issues facing the medical profession will be addressed by the Texas Medical Association House of Delegates at its meeting during the TMA Annual Session in San Antonio this month.

Policy on HIV-infected physicians, a dominant topic in recent sessions of the House, will again be on the delegates' agenda. Also under consideration will be the silicone gel breast implant controversy (See "TMA physician leaders study silicone breast implant issue," p 58.)

The House will meet in the North Banquet Hall, Convention Center, Thursday, May 14, 8 to 9:30 am, and Friday, May 15, 9 am to noon and 2 to 6 pm. Reference committee meetings will be held May 14, beginning at 10 am. All TMA members are invited to express opinions in reference committee sessions.

Among the other topics to be addressed by the House are:

- the recently issued OSHA regulations concerning bloodborne pathogens;
- support for programs to prevent family violence;
- requirements concerning informed consent for immunizations;
- issues raised by the introduction of Medicare's new resource-based relative value scale payment system;
- support for legislation to exempt states from federal emergency antidumping laws if the state has a comparable or superior hospital transfer law;
- support for legislation allocating physician licensure fees to the Texas State Board of Medical Examiners (TSBME) instead of to the general fund;
- corporal punishment in Texas schools;
- medical education issues including opposition to inappropriate intervention by the US Food and Drug Administration in continuing medical education (CME) accreditation, support for the new US Medical Licensing Exam, support for the continued voluntary status of CME, and opposition to board certification as a requirement for reimbursement or licensure; and
- new Centers for Disease Control standards for lead poisoning.

In addition, numerous resolutions from county medical societies will be before the House. At *Texas Medicine* press time, resolutions accepted as House business included calls for a TMA peer review service to investigate complaints about suspected impaired physicians; adjudication of all malpractice claims under TSBME; TMA support for establishment of goals by Texas medical schools for training increased numbers of primary care physicians; and opposition to restrictive federal legislation concerning referral of patients to facilities in which the physician has an ownership interest.

Texas Medicine will report action on the major topics in upcoming issues.

Corporate sponsors boost Annual Session

HELPING TO INSURE THAT high quality programs, speakers, and special events remain a part of the Texas Medical Association Annual Session are companies

Annual Session programs receive AAFP accreditation

IF YOU'RE PLANNING TO ATTEND the TMA Annual Session in San Ar tonio, May 14–17, take note that the American Academy of Family Physician has designated some 185 hours of prescribed credit for Annual Session pro gramming. The majority of other programs are acceptable for elective hours.

Also of note is that 250 CME hours are approved for Category 1 cred toward the American Medical Association Physician's Recognition Award.

and groups that participate in the Corporate Sponsorship Program.

At the top of the list of supporters of the 1992 Annual Session are four companies that provided financial grants at the "Platinum Sponsor" level. Those companies are:

- Glaxo Pharmaceuticals, Division of Glaxo Inc, Research Triangle Park, NC;
- Texas Medical Association Insurance Trust, Austin;
- Texas Medical Liability Trust, Austin; and
- Wyeth-Ayerst Laboratories, Philadelphia, Pa, Wyeth Division, Ayerst Division, Pediatric Division, A.H. Robins Division, and Elkins-Sinn Division.

The sponsorship program, which includes four levels of participation, offers companies the opportunity to sponsor special events such as the Annual Membership Luncheon or a program in a medical specialty.

Also providing support to this year's session are "Silver Sponsors" Allen & Hanburys, Division of Glaxo Inc, Research Triangle Park, NC; Ciba-Geigy Pharmaceuticals, Summit, NJ; Hoechst-Roussel Pharmaceuticals Inc, Somerville, NJ; Kabi Pharmacia, Piscataway, NJ; and Miles Inc Pharmaceutical Division, West Haven, Conn.

The "Bronze Sponsors" are Eastman Kodak Company, Irving, Tex, and Marion Merrell Dow Inc, Kansas City, Mo.

Companies wishing to sponsor events or programs of the 1993 Annual Session to be held in Houston, May 13–16, should contact the Department of Annual Session and Meeting Management, Texas Medical Association, 401 W 15th St, Austin, TX 78701, (512) 370-1450.

'Take charge,' declare TMA conference speakers

PHYSICIANS' NEED TO SPEAK out — and to be heard — in the widespread debate concerning US health-care reform was a key message at the TMA Winter Leadership Conference in Austin, February 29.

From the first moments of the conference, in the early morning packed-house session that analyzed public opinion about health-care reform, participants struggled to define the most effective ways to respond to the public's call for change. Moderated by Sue Rudd Wynn, MD, Fort Worth, chair of the TMA Council on Communication, the session focused on a recurring theme that physicians' strongest hope rests in remaining "in touch" with their patients about health care and reform. Also stressed was the degree to which Americans do not seem to realize that the health care they receive is of the highest quality in the world.

James H. "Red" Duke, Jr, MD, Houston, conference luncheon speaker, told participants in his own entertaining style about the way he tries to communicate with patients through his role as a spokesman for the "Texas Health Report," pr duced by The University of Tex Health Science Center at Houston.

"I'm basically a school teache said Dr Duke. "My main theme is try to get people to take responsibi ty for themselves and their actio and their health. My goal is to mal all of us geriatric doctors.

"You really gotta wanna conv information if you're gonna comm nicate," he drawled. "You gotta willing to make the effort, and y gotta speak in a language that t recipients understand, and then u whatever there is available to mal it easier to understand.

"I really believe that most peop are smart. I know that most — n all — have some real interest in the health and well-being and I really d believe if you give them informatio that they can assimilate, they wi somehow use some of it . . . not all it, you know; I mean you're not g ing to have a home run very ofte but you *will* make some impact."

Also emphasizing patients' role assuming responsibility for the health and the US health-care syste was one of the conference's feature speakers, Daniel H. Johnson, MD Metairie, La, speaker of the America Medical Association House of Del gates, whose topic was "Put the P tient in the Driver's Seat."

Arguing for a healt care system whose cos are controlled by the ma ketplace and not by "dra conian, top-down impos tion of price controls," D Johnson called for suppo of the AMA's Health A cess America plan fo health-care system refor

James H. "Red" Duke, Jr, MD

A LEGACY OF CARING GATHERS SUPPORT

DAN S. WILFORD, right, president of Memorial Healthcare Systems, recently presented a $10,000 contribution from Memorial to the TMA Education and Research Foundation's "A Legacy of Caring" Endow-ent Fund. Receiving the gift on behalf of TMA were, from left, Houston ysicians Max C. Butler, MD, state campaign chairman; TMA President m A. Nixon, MD; TMA Secretary/Treasurer Betty P. Stephenson, MD; and an C. Baum, MD, chairman of the TMA Board of Trustees. Income earned om the endowment will allow TMA to develop public health and medical ucation programs to benefit the people of Texas.

He also noted that the status quo s no longer viable.

"Change is not only inevitable, very desirable," he said. "Is there ybody here who believes that the Medicare and Medicaid programs are properly run?"

But, he said, the profession must stick together if it wishes to direct the changes.

"Your House of Delegates and the AMA House of Delegates offer a forum to reconcile the differences between specialties, between ages, between genders, between practice styles," said Dr Johnson. "We have this situation where people keep running off to cut their own deals. We offer a forum to reconcile those differences so that we can walk out of that forum locked arm-in-arm, united in our solutions."

niel H. Johnson, MD

MA President Sam A. Nixon, D, left, presents James R. Hick- a plaque commending him for tstanding service to the physi- ns of Texas. Mr Hickox, who ired at the end of 1991 as exec- ve director of Harris County edical Society, worked in orga- ed medicine more than 30 rs. He was recognized at the MA Winter Leadership Confer- ce February 29 in Austin.

You can help build a stronger federation

PHYSICIANS WHO WISH greater numbers of their colleagues were TMA and AMA members are needed for two activities that are part of the TMA 1992 Outreach Program.

During the 1992 Annual Session Phonathon —patterned after last year's successful campaign — member physicians or medical students will telephone members who have not renewed TMA or AMA dues and ask them to reconsider. Last year, almost 95% of those contacted rejoined TMA.

The phonathon will be held in Rooms 2605 and 2607 of the San Antonio Marriott Riverwalk Hotel in conjunction with the TMA Annual Session. Times are May 13 from 3 to 5 pm, and May 14 and 15 from 8 am to 5 pm, but some evening hours may also be available.

The second part of the membership drive, to be launched during Annual Session, is the 1992 "peer-to-peer" program that gives participants names of prospective members to contact either by phone or by letter. Participants also receive a packet of materials containing details on effectively recruiting new members. The deadline for recruiters to get credit for nonmembers who join is February 28, 1993.

Certificates of recognition and awards will be presented to participants who successfully recruit new members in both the phonathon and the peer-to-peer program.

If you can help with either program, contact Amy Bruno, TMA membership department, (800) 880-1300 or (512) 370-1443, or come by the "Outreach Desk" near the entrance to the House of Delegates meeting in the North Banquet Hall of the San Antonio Convention Center.

COMMENTARY

A doctor votes for universal access

George L. Bohmfalk, MD
1001 Main St, Texarkana, TX 75501

A RECENT LETTER TO THE editor (*Texas Medicine*, February 1992, pp 9–10) suggested that we could eliminate the majority of non-emergency ER visits by Medicaid patients by docking $25 from the ER-abusing patient's next "public assistance check" for each inappropriate ER visit. This proposal sadly exposes the extent to which "the enemy is us." The complaint — that emergency rooms are misused as after-hours clinics by nonfunded or underfunded patients and that physicians in smaller communities find themselves obliged to care for those patients — is legitimate. But the suggestion that we solve this manifestation of lack of access to care by restricting the access even further with a garnished co-pay is wrong in basis, concept, and spirit.

The proponent assumes that such a copayment will discourage ER abuse; I am unaware of any evidence to that effect. These poor persons, unwelcome at too many of our private offices, seek care where and when they are able. They do not choose to wait in ERs for hours in the middle of the night; that's the only time they can get someone to bring them. We may quickly discern, to our displeasure, that they have only minor ailments that could have waited until morning. But they are frightened by their symptoms, and they dread hearing a condescending, "Well, if you'd only have come in sooner, we could have made everything wonderful." Rather than solving the problem, the more likely scenario with this proposal is just that: that patients who are successfully dissuaded from seeking non-emergency medical care will deteriorate and present a few days later with genuine emergencies at 4 am, or even worse, at 2 pm while we are busy with scheduled work.

This proposal is short-sighted, ill-conceived, and patronizing toward the poor, whom we often blame for making part of our practices unpleasant. Unfortunately, this type of thinking is representative of most of the rhetoric we hear and read from fellow physicians about how to fix our health-care system. Few of us bother to gather facts or to learn how situations evolve; but we are quick to espouse simplistic solutions, nearly all of which involve making someone else change what he's doing, while we continue on our supercilious independent ways, rarely having to account for how we spend other people's money.

Time, money, and the public's patience are rapidly running out.

Time, money, and the public's patience are rapidly running out. It is inescapable that we physicians assume greater responsibility for the costs of health care. Our failure to do so is largely why insurance companies are now trying to manage us. The solutions to our health-care problems are not to be found in copayments by the poor, pay-or-play, caps on jury awards, income tax credits, expansion of Medicaid, hassling of doctors, repeal of RBRVS, or other stopgap, Band-aid, painless, politically expedient approaches. The solution to the ER abuse problem, and to most of what else ails health care in America, is a program of universal coverage. Health care is a rig in every industrialized country exce the United States and South Africa. is only civil finally to acknowled health care as a right here. It is tir for physicians to open our minds a take a thoughtful look at the conce of universal coverage, rather th reflexly denouncing it without exam nation as unacceptable "socializ medicine." If we were to take a fra tion of the mind power, time, mon and energies that we use our obstinate resistance national health care and d vote it to devising ar agreeing upon a ration program, we could doub less arrive at the world best system and avoid ha ing an ill-fitting importe one thrust upon us.

Nothing mandates th government has to run program of national heal care. I believe that gover ments would love to ha this problem go away; th have become the provide of last resort. It is entirely reaso able that private business, appropr ately regulated and monitore could administer a system of natio al health care and make a profit. A income tax-funded program of un versal coverage administered b large, private organizations in whic physicians, hospitals, and oth "providers" (sorry, but we do pr vide care) have clear-cut incentiv to control costs is the only option can envision that has any ho of success and acceptance b physicians, patients, privat industry, and politicians. Th organizations, hybrids of insuran companies and HMOs, would con pete for enrollees, whose unifor premiums would be paid directly b

e federal government. Those com-
nies that manage the health care
their enrollees efficiently will be
ofitable and healthy themselves.
ysicians will have vested interests
both their patients' welfare, as al-
ıys, and the welfare of the compa-
es with which they participate, as
indispensable feature of any ef-
ctive cost control mechanism. Our
ıys of exhorting, "I'll do as I think
st, without regard for the cost!"
ve been ended by unbearable costs
ıd the realization that other physi-
ans can produce equal results for
wer dollars. Society, as well as ra-
onal thinking, demands that we ac-
nowledge that in our actions.

What about tort reform? What
out freedom of choice, salary ver-
s fee-for-service, rationing, unnec-
sary surgery, waiting lines, and a
illion other important details? Tort
form, and with it the costs of de-
nsive medicine (whatever that is),
orbitant malpractice premiums,
ıd the declining availability of ob-
etricians and emergency rooms,
ill be dealt with by the larger soci-
y, inasmuch as the issues that are
obvious and crucial to us physi-
ans are only a portion of a much
rger, generalized liability crisis. Ty-
g tort reform specifically to health-
ıre reform is inappropriate and ill-
ted. Formidable pressure to make
ıeir systems more functional is be-
ıg felt by both the legal and the
ealth-care industries, and the sys-
ms will change. The other details
re just that. Once all Americans
ave genuine access to basic, neces-
ıry health care, and we no longer
ıtion by job status, preexisting con-
itions, state of residence, or other
indrances to one's ability to pay,
he central health-care issue will
ave been solved, and we may more
easonably negotiate the remaining issues. In a system of private, competing companies, these considerations may be settled much more satisfactorily than through endless congressional hearings and rule-making. With an expanding, aging, and longer-living population and more expensive technology, total health-care costs and their percentage of the gross national product may continue to rise, but care will finally be available to all, and physicians will responsibly be part of the solution rather than scapegoats for the problem.

With a universal health-care program, many of us may pay more income tax, but our taxes will still be lower than in most industrialized nations. We can delight in the consolidation of Medicare, Medicaid, Workers, Compensation, CHAMPUS, and 1,500 insurance companies, each with its own particular quirks, demands, and irritations, as order comes out of chaos. With such a program, poor, but now funded, patients will be seen in our offices during the day, rather than in our ERs at night. We may perhaps even see them more efficiently and with lower overhead, if the present paperwork overloads are lightened by streamlined administrative systems. Our present "delinquent accounts" personnel may be put to more productive use, and collection agencies can return to concentrating on automobile and house payments, rather than medical bills. We will be associates, rather than adversaries, of business persons in these organizations, as all of our jobs, salaries, fees, and bonuses hinge on our combined efficiencies rather than on how much we do to a patient. We will waste less time with pharmaceutical representatives and junk mail as companies learn that doctors are influenced more by "The Medical Letter," outcomes research, and scientific reports than by their pressure, propaganda, and geegaws. Doctors will always be able to earn respectable incomes for hard work, although, God willing, we should no longer have to be embarrassed by physicians making million-dollar annual fortunes. Or is that why some of us went into medicine?

We must stop blaming everybody else for the high costs of health care, and we must participate in the solutions to our health-care crisis. It's by no means all our fault, but we are part of the problem. Until we are willing to offer real solutions and to assume more responsibility ourselves, outside pressures will impose less desirable changes upon us. And soon. ★

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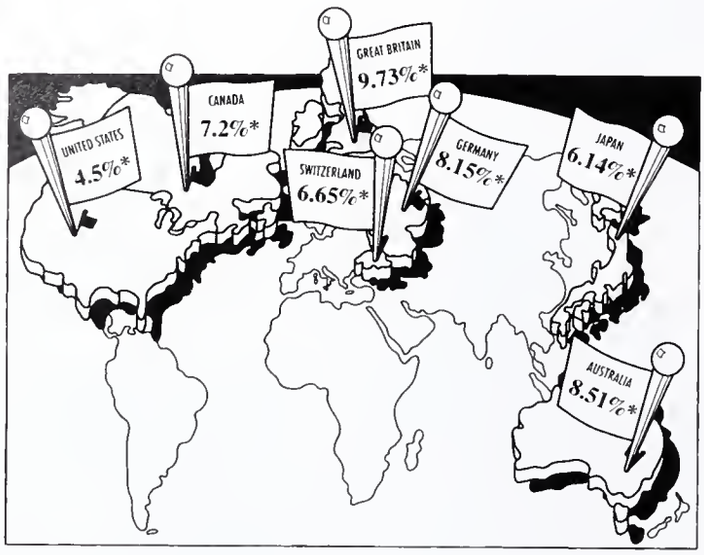

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Example of Foreign Currency Investment Returns
Returns on 3 month Time Deposit from 8/14/91 thru 11/14/91

	Australian Dollar	British Pound	German Mark	Japanese Yen	Swiss Franc	Canadian Dollar	U.S. Dollar
Interest Rate	8.51%	9.73%	8.15%	6.14%	6.65%	7.2%	4.5%
Foreign Exchange Gain (Loss) over 3 month period	-2.89%	3.48%	4.75%	2.98%	2.93%	-0.31%	n/a
Projected Return	5.62%	13.21%	12.9%	9.12%	9.58%	6.89%	4.5%

Return on foreign currency deposit investment is comprised of both interest earnings and capital gain or loss. The amount of gain or loss depends on the underlying value of the investment currency relative to the U.S. Dollar when the investment is reconverted.

For example, $25,000 invested on 8/14/91 at the prevailing exchange rate on that date of 1.717 DM to the Dollar, would have bought 42,925 DM. Invested in a 3 month time deposit at prevailing interest rates, this investment would have earned 875 DM through 11/14/91. Therefore total principal and interest on 11/14/91 would equal 43,800 DM. If this investment were reconverted to U.S. Dollars on 11/14/91 at the then prevailing exchange rate of 1.6406 DM to the dollar, the investor's deposit would be valued at **$26,697**. The return on the investment would be equal to the interest over the period of $510 plus foreign exchange capital gains of $1,187. Total return on the investment is calculated as the annual interest rate of 8.15% plus capital gains over the three month period of 4.75%, which is projected as representative for the full year, for a total return of 12.9%.

Total returns in the chart assume that the three month experience is typical for the full year. Interest rates as well as foreign exchange capital gains or losses may vary significantly from this example. This example is for illustrative purposes only and is not indicative of future performance or returns.

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People

NEWSMAKERS

Lawrence M. Brubaker, MD, a Harker Heights family practice physician and major in the Army Reserve, was awarded the Bronze Star Medal by the US Army for his service during Operation Desert Storm.

Jason H. Calhoun, MD, and **Clay J. Cockerell, MD,** have been chosen for two of the five associate councilor positions for the state of Texas in the Southern Medical Association. Their responsibilities will include assessing physician education programs at hospitals and universities, and developing and promoting continuing medical education programs for physicians. **Dr Calhoun** is an orthopedic surgeon in Galveston. **Dr Cockerell** practices dermatology and pathology in Dallas.

El Paso child psychiatrist **Walter Farr, MD,** has been appointed for a 3-year term to the medical advisory committee of the Texas Department of Mental Health and Mental Retardation. The committee makes recommendations to the TXMHMR board concerning mental health and mental retardation needs of the state and suggestions regarding the quality of patient and client care.

Killeen general surgeon **Frank E. Siemma, MD,** has been elected president of the Bell County Medical Society.

Please let *Texas Medicine* know about your honors and achievements.

Criteria for inclusion in the Newsmakers section are: TMA member; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, Texas Medicine, *401 W 15th St, Austin, TX 78701.*

A. Earl Mgebroff, MD, Yoakum, was reappointed to the Commission on Membership and Member Services of the American Academy of Family Physicians.

The Society of Surgical Oncology presented the Lucy Wortham James award to **Jack A. Roth, MD,** chairman of the Department of Thoracic Surgery at The University of Texas M.D. Anderson Cancer Center. This award, the society's highest honor, recognizes Dr Roth for his outstanding contributions in clinical oncology research.

Dermatologist **Shelley Sekula, MD,** has been elected secretary/treasurer of the Houston Dermatological Society.

Ciro V. Sumaya, MD

The Association of Academic Health Centers has chosen San Antonio pediatrician and pathologist **Ciro V. Sumaya, MD,** for the charter class of six scholars in academic administration and health policy. The group will act as consultants to the association and help develop the details of the new program. This organization is designed to encourage mentoring and networking of young health professionals who want to combine the study of high-level administration with traditional academic pursuits.

OBITUARIES

James W. Atchison, MD, 83; Gainesville; The University of Texas Medical Branch at Galveston, 1935; reported deceased.

Calvin W. Harris, MD, 76; Dallas; The University of Texas Southwestern Medical School, 1942; died February 25, 1992.

James B. Ivers, MD, 68; Beaumont; The University of Texas Medical Branch at Galveston, 1948; died March 2, 1992.

Graeme S. Maclean, MD, 42; Dallas; The University of Texas Southwestern Medical School, 1986; died February 17, 1992.

Oscar P. Milanes, MD, 35; Amarillo; Texas Tech University School of Medicine, 1983; died February 25, 1992.

Phillip N. Mitchell, MD, 28; Ft. Worth; The University of Texas Southwestern Medical School, 1991; died February 8, 1992.

George E. Rabinowitz, MD, 74; McAllen; The University of Texas Medical Branch at Galveston, 1942; died March 4, 1992.

W.D. Tigertt, MD, 76; Maryland; The University of Texas Southwestern Medical School, 1937; died January 19, 1992.

Richard L. Vardy, MD, 61; Lubbock; The University of Texas Southwestern Medical School, 1955; died February 22, 1992.

Carlton Edgar Wolters, MD, 78; Houston; Baylor College of Medicine, 1942; died February 17, 1992.

Oscar Yero, MD, 66; Austin; Havana University Medical School, 1950; reported deceased.

Public Health

AMA, surgeon general urge cancellation of Old Joe campaign

OLD JOE CAMEL HAS TO GO. That's the desire of the American Medical Association and US Surgeon General Antonia Novello, MD.

"In years past, R.J. Reynolds would have us 'Walk a mile for a Camel,'" says Dr Novello. "Today, it's time we invite Old Joe Camel himself to take a hike."

The furor over the controversial advertising campaign for Camel cigarettes erupted following studies published in the December 1991 issue of the *Journal of the American Medical Association (JAMA)* that revealed Old Joe's recognition factor among 6-year-olds was equal to their identification of the Disney Channel Mickey Mouse logo. Related studies also showed that tobacco advertising promotes and maintains nicotine addiction among children and adolescents.

"There is no doubt in my mind the Camel campaign is directed toward kids."

Agreeing with the study is Joel Dunnington, MD, chairman of the Texas Medical Association Task Force on Tobacco Use Prevention. "There is no doubt in my mind the Camel campaign is directed toward kids," says Dr Dunnington.

"The number one thing we need to do is enforce the access to minors law (which prohibits tobacco sales to minors)," says Dr Dunnington. "We have a law in Texas, but nobody enforces it."

Dr Dunnington says of all the studies that appeared in *JAMA* concerning tobacco advertising, the most important one was on the cigarette control laws in Woodridge, Ill. The study concluded the enforcement of laws can be effective in reducing the sale of tobacco products to minors. "It's like when my 4-year-old is upstairs in the bathroom and I see water pouring down around the chandelier and running down the stairs. Do I mop the floor first or turn the water off?" says Dr Dunnington. "Of course, I turn the water off first."

AMA Executive Vice President James S. Todd, MD, says the advertising and promotion of Camel cigarettes has been targeting children and "must stop."

"By withdrawing all Old Joe Camel advertising, R.J. Reynolds can take a responsible stand and help prevent children from smoking," says Dr Todd.

TMA opposes tobacco ads

Opposition to tobacco advertising in all forms: explicit and subliminal. That's one of the policies of the Texas Medical Association on tobacco. The association also urges all athletes and sports representatives to disassociate themselves from all forms of tobacco advocacy and use. TMA also has requested the American Medical Association to urge Congress to extend the current advertising ban to print media and billboards as well as the electronic media.

In addition to the above policy, TMA supports:

- including on the death certificate in Texas a list of choices und the heading of "death attribut to tobacco;"
- a smoking ban in all educatio facilities in Texas, public, and pr vate, from elementary throug collegiate level, and TMA an Texas Pediatric Society encourag smoking cessation programs fo employees, faculty, staff, and stu dents of these institutions;
- an end to all price supports fo tobacco;
- regulations banning smoking o domestic airplanes, legislation t prevent smoking in public place and the allocation of part of th cigarette tax for support of loca antismoking programs;
- prohibiting smoking in any pub lic place;
- endorsement of Texas Hospita Association's recommendatio that all hospitals be smoke-free;
- smoke-free physicians' offices;
- implementation of a smoke-fre policy in all state hospitals, in cluding psychiatric hospitals;
- legislative action banning smok ing in all hospitals;
- divestiture of tobacco invest ments, especially by physician and health-related institutions;
- classification of tobacco smoke a a Class A carcinogen and strin gent regulation with other Clas A carcinogens regulated b OSHA and the EPA; and
- a complete ban on sales o cigarettes from vending ma chines; bans on the distributio of free samples of cigarettes; an revocation of license for sellin tobacco to minors.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

AGENDA ON AIDS

Clinic develops HIV education program for deaf, hearing impaired

A *deaf or hearing impaired individual* learns he or she is HIV positive. They are now in search of information, treatment, and understanding. Is elp available for this patient population?

An educational outreach program has been developed by the Montrose Clin- in Houston that links deaf and hearing impaired patients with counseling and ıformation resources. Supported through funding from the United Way, Hous- ›n Endowment, and Moody Foundation, the program provides services in 11 ›unties along the Texas Gulf Coast. In addition to the outreach program, the exas Department of Health has recently awarded a $56,000 grant to the clinic ›r the development of an HIV counselor training program for the deaf and earing impaired. The clinic also has designed AIDS education brochures to pecifically meet the needs of the deaf and hearing impaired population.

"We are trying to deliver the disease prevention message from the deaf erspective," says Bert Bares, program director for the deaf and hearing im- aired education outreach program. "We are taking a proactive approach nd are looking at ways to expand the program."

For medical facilities working with HIV positive and AIDS patients, a nedical survival skills class that offers American Sign Language instruction s available along with a deaf sensitivity workshop. Physicians interested in he Montrose Clinic programs can contact Mr Bares at (713) 528-3719.

ources: Texas Department of Health, HIV Division, Bureau of HIV & STD Control.

Several patients have asked me about the effectiveness of condoms in protecting against HIV transmission. How much protection do they provide?

C *ondoms are not completely protective.* Married couples using condoms as a means of birth control experience a 10% to 15% failure rate per year. The easons for those failures seem to be a combination of condom failure, improper ıse (eg, failure to use them from beginning to end, failing to withdraw upon or- gasm, etc) and not having them available at the time when intercourse is desired. Conception seems to occur more often per act of intercourse than HIV transmis- ion, which may occur as infrequently as once per 100 acts of vaginal intercourse. Anal intercourse is more likely to transmit the virus and seems to carry a greater isk of condom failure. Oral intercourse is both less risky and less likely to cause condom damage. Thus, condoms can be considered to be risk reducers not risk eliminators. A special case is the non-latex condom. Studies have shown that it is porous enough to allow the passage of the virus even if the condom is not dam- aged. Patients should be warned not to use so-called "natural condoms."

Source: Richard M. Grimes, PhD, director of the AIDS Regional Education and Training Cen- ters for Texas and Oklahoma at The University of Texas at Houston School of Public Health. Dr Grimes will provide answers to questions about AIDS each month in this column. For fur- ther information about this topic or any HIV topic, call the AIDS Helpline for Health Profes- sionals at (800) 548-4659.

Query letters discover missing death certificate info

The public health of Texans is enhanced through the use of statistical information gathered from death certificates. This is the second installment in a look at the data collected by the Texas Department of Health and the role physicians play in helping to provide information.

IT CAN AT TIMES BE LIKE searching for the missing piece to a puzzle. But through the combined efforts of physicians and the Texas Department of Health, elusive information needed to complete the death certificate filing process can be found.

With about 10,000 death certificates coming into the TDH Bureau of Vital Statistics (BVS) nosology branch each month, there are instances when additional information is needed to complete the filing requirements. When this occurs, a query letter is sent to the individual who certified the death.

TDH uses the International Classification of Diseases to classify the deaths. The two main objectives are to ensure accuracy of the reporting and classification of each death and comparability of the data for the study of trends and causes of mortality.

"Many of the doctors will go out of their way to provide us with information," says Kathy E. Sellstrom, supervisor for the BVS nosology branch. Ms Sellstrom says about 8% of the death certificates require query letters.

These letters are sent to the certifier of death (attending physician or coroner) when there are questions about information in the cause-of-death section. The form letters con-

tain a general introduction describing why the information is needed and what additional information is being requested. Information from the original death certificate is transferred to the query letter.

The physician might receive a query letter that contains one or more of the following requests:

- There is difficulty assigning an underlying cause to this death as stated on the certificate. When a mental condition is reported as the only condition on the record, we need to know the mechanism of death. Based on your (certifier of death) best judgment and knowledge of the facts of this case, was there an underlying disease, abnormal physiological condition, or specific injury relating to this death?
- Some conditions are considered symptoms, signs, or are ill-defined and would rarely cause death except in conjunction with other conditions. In order to classify this death by the most accurate underlying cause, more information is needed.
- When the death certificate states that surgery or medical care was given without any additional information, the condition that necessitated it is needed in order to classify the death correctly. Please provide the information checked below: condition that necessitated surgery; condition that necessitated the stated medical care or therapy; condition that required drugs or medicaments; or specific treatment or surgery.
- The cause of death includes an external cause. More details are requested. Please use the following as a guide: factors relating to the death such as a fall (slipping, stumbling, fall on stairs, fall from chair, bed, ladder, roof, cliff, or building); burns (open fire, matches, radiation exposure, explosion, or caustic agent); poisoning (lye, overdose of drug, chemical, pesticide, rat poisoning or carbon monoxide); firearms (how it happened and type of gun); cuts (pin, nail, ax, or knife); animal (how it happened such as dragged by, thrown from, mauled, bitten, gored, or trampled); machinery (type of machine and how it happened) or motor vehicle. In the event of a motor vehicle accident, there are also requests for the type of collision and what or who was involved, such as pedestrian, other motor vehicle, railroad train, bicycle, animal, or fixed object. In addition, the status of the decedent should be specified, for instance: driver, passenger, pedestrian, or pedal cyclist.

"The querying process has resulted in a significant improvement in the reporting of causes of death," says Ms Sellstrom. Physicians are encouraged to contact TDH at (512) 458-7359 in the event they have questions concerning the query letters.

COMMENTARY

Tetanus cases preventable with immunizations

Jan W. Pelosi
Texas Department of Health
Infectious Diseases Program
Epidemiology Division

TETANUS IS A SERIOUS, but preventable neurological disease. Although the incidence of tetanus is now low, cases continue to occur. Ten cases of tetanus were reported to the Texas Department of Health (TDH) during 1991; three of these individuals died.

The age of the patients ranged from 6 to 98 years old. All of the patien were inadequately immunized, and i fact, six patients had never been vacc nated against tetanus. In spite of th fact that tetanus toxoid is one of th least expensive and most effective bio logicals available, many Texans, espe cially adults, are inadequately immu nized against the disease. Even th 6-year-old child who was diagnose with tetanus in 1991 had never bee vaccinated against the disease.

Students who are 5 years old an older and enrolled in elementary o secondary schools are required t have received at least three doses o DTP, DT, or Td vaccine, at least on dose of which was received on or af ter the fourth birthday. The chil who was not vaccinated had no been enrolled in any public or pri vate school, and therefore slippe through the cracks of the system.

TDH recently surveyed each o the hospitals in Texas where cases o tetanus were treated and learned tha the 10 cases incurred hospita charges that totaled more tha $878,500 collectively. This dolla amount reflects hospital costs onl and does not include any physicia fees. Hospital stays ranged from 3 t 93 days. Patients with the shortes hospital stays (3, 6, and 7 days) wer those who died, and those who re covered stayed in the hospital an av erage of 41 days. TDH reports that single dose of the combined tetanus diphtheria toxoid (Td) costs the stat less than 15 cents and a single dos of DTP vaccine costs $6.25 per dose It is estimated then that all 10 case could have been fully immunize against tetanus for less than $25. I turn, the $878,500 it cost for the 1 cases could have been used to pur chase just under 6 million doses o vaccine, enough to administer th complete primary series to almost

llion unvaccinated adults.

Tetanus toxoid produces long-rm immunity, and in most people, is immunity will last for 10 years longer. Although some of today's unger adults received the primary ries of DTP vaccine as children, ey have not received their "boost-" doses at the recommended 10-ar intervals. Only one dose of tanus toxoid administered to an lult who received the complete pri-ary series is sufficient to protect em from tetanus for another 10 ars. Persons who have not com-eted the full primary series or hose immunization status is un-nown or uncertain should receive tanus toxoid when they seek medi-l attention for any injury or ound. Persons who are uncertain as their primary vaccine status ould be considered not immunized. ecause many adults also lack pro-ctive levels of circulating antitoxin gainst diphtheria, Td is recommend-l for adults in both routine and inical and emergency room settings.

Although Texas physicians rou-nely immunize children and adoles-nts with the vaccines required for hool attendance, they should also ake sure that all their infant and dult patients are immunized as well.

Infants should begin their DTP vac-ne series at 2 months of age, and dults should receive booster doses of d every 10 years. Older adults and the derly, especially those who live alone, re probably at greatest risk of develop-g tetanus since they are less likely to ek medical attention for what they erceive to be minor or insignificant in-ries. The severity of a wound should ot necessarily be a consideration for accination; many of the tetanus cases eported in Texas have been associated vith minor injuries, such as scratches, mall cuts, and burns. ★

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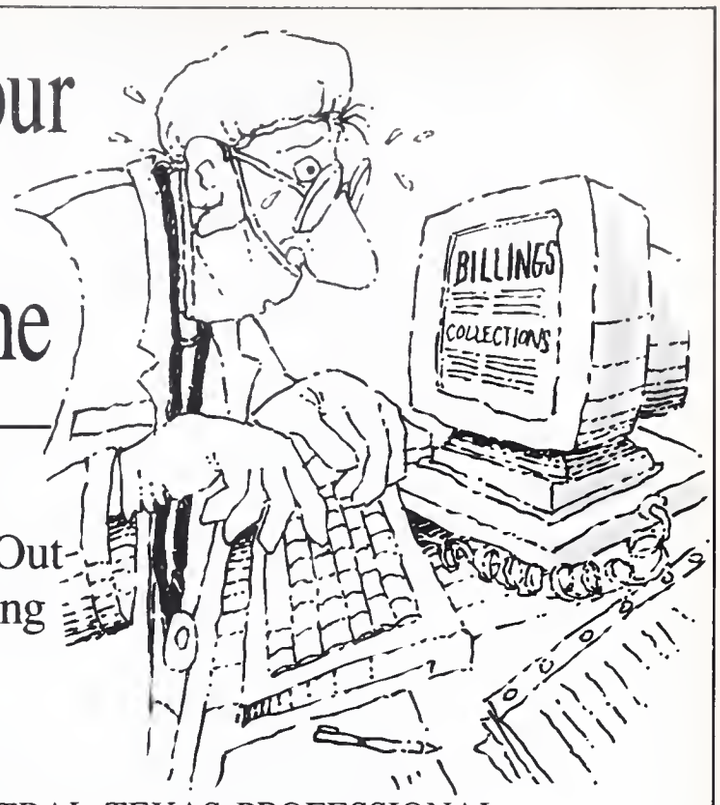

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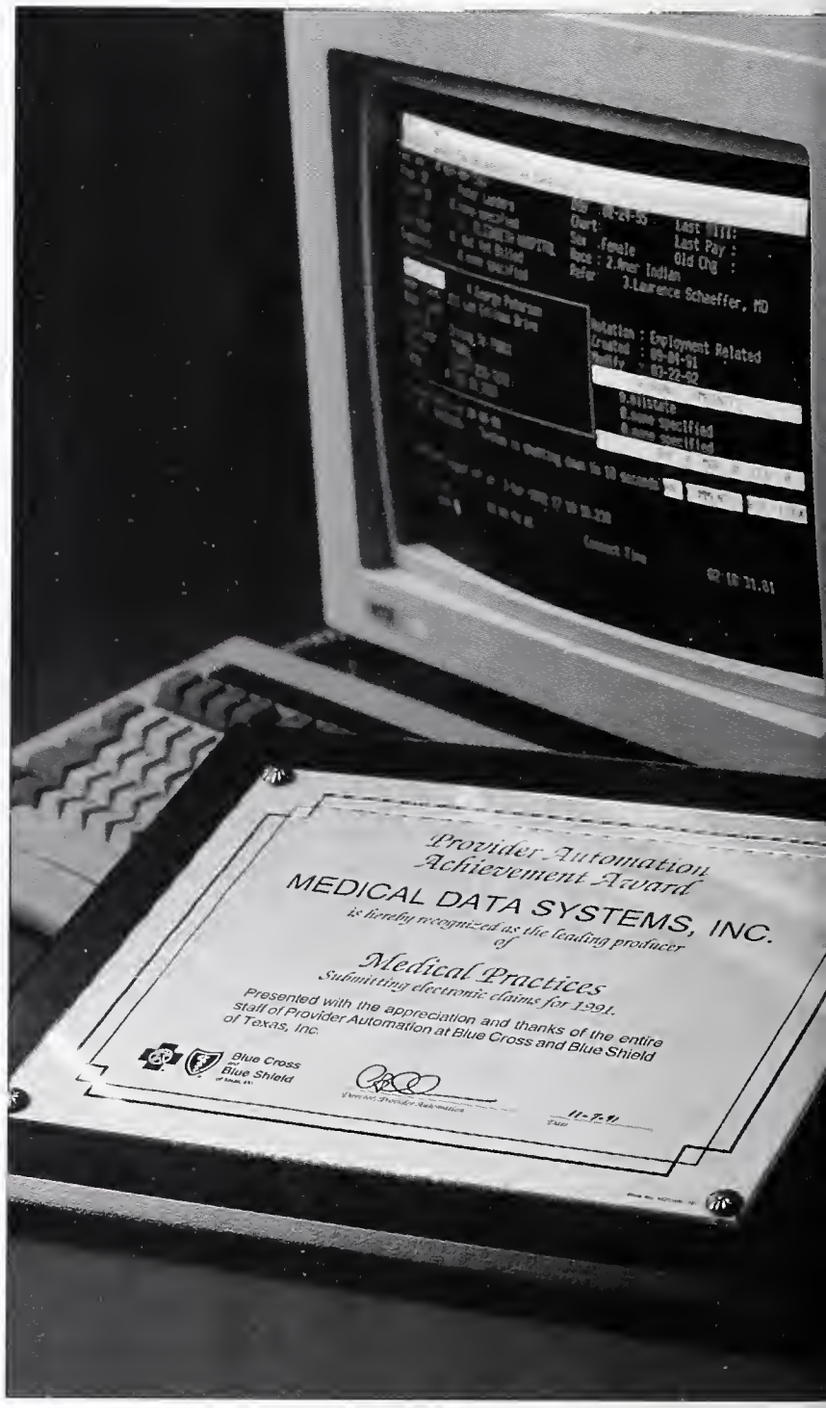

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Medical Economics

Consultants advise physicians to get involved in managed care

LIKE DEATH AND TAXES, managed care is an inevitable part of the future, according to health-care consultants. And if physicians don't become involved in the development of managed care plans now, they face another inevitability: the government will do it for them.

Speaking at the TMA Winter Leadership Conference February 29 in Austin, Dennis L. Copfer, a consultant for Foster Higgins Inc of Dallas, and John A. Deane, executive director of UT-Med Group Practice in Galveston, presented a program, "Rising Costs: Is Managed Care the Answer?" to physician leaders.

The consultants told the gathered physicians that recent increases in the number of health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service (POS) plans are just the beginning of an explosion in the use of managed care to control rapidly rising health-care costs.

"Physicians cannot afford to sit back and let HMOs, PPOs, and other third parties decide the future of how health care is to be managed," said Mr Deane. "Physicians must belly up to the table and take a leadership role in deciding just how health care is to be managed."

In 1990, 38% of employees nationwide were enrolled in managed care plans, up from 27% in 1987, according to Mr Deane. Over the same period, he noted, employee health coverage in "unmanaged" conventional plans declined from 41% to only 5%. The remaining 57% represents traditional plans that employ utilization management.

John A. Deane, executive director of the UT-Med Group Practice, tells TMA physician leaders that they must become involved in developing managed care plans in Texas or accept what the government gives them.

In addition to HMO enrollment, more than 38 million Americans were eligible to use PPOs in 1990. Enrollment in PPOs is growing at a national average annual rate of 46%.

Texas has a lower HMO market penetration than the national average, Mr Deane said. As of 1980, Texas had 91,000 or 0.6% of the population. By 1990, that number had grown to 1.1 million, or almost 7% of the state. However, PPO growth in the state has increased rapidly, with the number of PPO organizations growing from 21 to 5 between 1987 and 1990.

"Both employers and the federal government appear to have embraced managed care in an attempt to slow the rapid increases in health care spending," said Mr Deane. "As a consequence, managed care has grown rapidly and constitutes an increasing share of both government and commercial health coverage.

"Unfortunately, managed care has not lived up to its promise," he added. "Instead, we have witnessed the development of marginally effective, follow-the-leader, regulatory interventions that are concerned mor

Distribution of US employees across health benefit plans.

Type of Plan	1987	1988	1989	1990
Conventional without utilization management	41%	28%	18%	5%
Conventional with utilization management	32%	43%	49%	57%
Total non-network plans	73%	71%	67%	62%
Health maintenance organizations (HMO)	16%	18%	17%	20%
Preferred provider organizations (PPO)	11%	11%	16%	13%
Point-of-service plans (POS)	–	–	–	5%
Total network-based managed care	27%	29%	33%	38%

Source: HIAA Employers Survey, 1987–1990

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

th restricting benefits and hassling ysicians than in developing truly st-effective programs."

Mr Deane noted that trends in naged care include:

Plans tend to build a network of physicians and hospitals, build market share, and then tighten the network by closing provider panels and failing to renew selected provider contracts.

Fee schedules and capitation are being used more and more to control costs.

Third-party utilization management techniques are becoming increasingly stringent, while more plans are developing physician profiles detailing practice patterns.

Mr Copfer discussed health-care sts primarily from the point of w of employers, noting that many e moving toward managed care ns as a cost-saving measure without considering the effect on the ality of care.

"Medical costs as a percent of aries will rise from just 7% in 86 to a projected amount of 16% 1994," he said. "This gives employers a tremendous incentive to ntrol health-care costs. Physicians ed to form partnerships with employers to help control the costs and ve a say in the process."

He noted that a health-care nefits survey of employers done by ster Higgins showed an unrelenting cost trend in medical plans; increased cost-sharing with employees; nost universal application of imnity plan cost management ls; and growth in the acceptance managed care plans.

"So with all this, why are costs continuing to escalate?" he asked. "It's nd in the costs of uncompensated e, Medicare/Medicaid cost shifting, and limited cost management."

Mr Copfer strongly encouraged TMA physicians to take a leadership role in developing managed care in Texas, listing several reasons why it is critical.

"With financing changing the delivery system, physicians can best shape the future of managed care," he said. He also added that some managed care plans are "physician friendly," and TMA could have an influence on how those are developed.

He added that new jobs and patients are possible with increasingly competitive Texas medical costs, collection problems are lessened with more managed care benefits, independence and control of destiny are more viable with managed care than with national health insurance, and managed care allows physicians to focus more on quality patient care.

Council on Socioeconomics endorses RBRVS action plan

THE TEXAS MEDICAL Association Council on Socioeconomics has approved implementation of the TMA Action Plan developed to counter many of the problems with the new Medicare RBRVS payment system, particularly those involving the geographic practice cost indices (GPCIs).

Meeting February 28 at the Winter Leadership Conference in Austin, the council discussed the substantial efforts TMA has made in attempting to improve the accuracy of the flawed GPCIs in the RBRVS system. The council was told that TMA has already:

- corrected technical locality problems resulting in an additional $14 million for Texas physicians;
- inserted a GPCI update provision into the law where one did not exist;
- moved the GPCI issue to the top of the AMA's and other state medical societies' agendas; and
- provided data necessary to improve the reliability of the GPCIs.

TMA has worked closely with Congress to introduce legislation addressing the GPCI problems. (See "Legislation filed to correct GPCI errors," p 62.)

The council voted to recommend that TMA submit a resolution to the AMA requesting that organization's strong support for legislation to improve the GPCIs. In addition, the council recommended that the provision of an annual GPCI update be included in the bill.

The council also echoed the position of the AMA that TMA not endorse the RBRVS system until substantial improvements are made, including the items included in the TMA Action Plan. (See "TMA develops action plan to help physicians cope with RBRVS," *Texas Medicine*, March 1992, p 40.) It was further recommended that legislative, regulatory, and legal efforts be made to resolve payment problems and inconsistencies in the implementation of RBRVS.

In other action, the council:

- requested staff to draft a recommendation for the TMA Policy Manual on support for affordable basic health-care benefits available to small employers for review by the council at its May meeting;
- recommended that TMA submit a resolution to the AMA requesting opposition to implementation of the required use of a uniform clinical data set by the PRO until

a computer program is fully documentable, algorithms are understandable, confidentiality concerns are addressed, and the effect of practice parameters under development by specialty societies are fully evaluated;

- instructed staff to organize a HCFA presentation to the council in May on new CLIA regulations; and
- requested staff to seek an extension of the compliance deadline for new OSHA regulations.

OBRA '87 changes in nursing home care published

THE OMNIBUS BUDGET Reconciliation Act of 1987 (OBRA '87) made significant and extensive changes in the requirements and standards for nursing homes and the treatment of patients in nursing homes.

While many of these requirements have gone into effect over the past 3 years, the Health Care Financing Administration (HCFA) continues to implement and modify the regulations resulting from OBRA '87. (See "OBRA '90: The good news," *Texas Medicine*, January 1991, p 62.) Significant changes have been made in the final regulations, which went into effect on April 1, 1992.

Among the major changes pertaining to physicians are:

- A physician's approval of a recommendation to admit a person must be in writing.
- Physicians must date all orders.
- The regulation regarding the current frequency of visit intervals applicable to Medicaid nursing facilities is deleted and the requirements, formerly applicable to Medicare residents, now apply to all long-term care facilities. After admission, physician visits must occur every 30 days during the first 90 days and every 60 days thereafter.
- All physician tasks except certification, recertification, and the ordering of medication and treatments may be performed by a nurse practitioner, clinical nurse specialist, or physician's assistant who is not an employee of the facility and who is working in collaboration with a physician.
- The requirement for a "drug holiday," or regular periods off of antipsychotic drugs, is deleted from the regulations.

The above are only excerpts from the final published regulations. If you have questions or would like a copy of the entire text of the final regulations, contact Rose Davis, RN, at the Texas Department of Human Services at (512) 450-3529. ★

TMA OFFERS PHYSICIAN'S GUIDE TO WORKERS' COMPENSATION

SINCE THE PASSAGE OF workers' compensation reform legislation i 1989, Texas physicians have encountered a significant increase in th amount of "hassle" involved in dealing with workers' compensation cases

TMA has prepared a 60-page booklet, "Workers' Compensation: A Bri Guide for Texas Physicians," which not only explains the law and associate regulations, but relates the experiences of many physicians and office ma agers in practices where workers' compensation cases comprise a large po tion of the patient load.

"Doctors have been saddled with insurance problems, fourth-party r viewers, and new forms with the reform of workers' compensation," sai David Marcus, PhD, TMA director of health-care financing. "It has become world-class hassle."

The publication focuses on assisting physicians in filling out forms and re ports required by the Workers' Compensation Commission, billing the prope amount for the proper services, dealing with fourth-party reviewers, doin impairment ratings in the absence of the proper impairment guide, and treat ing workers outside the system.

The focus, according to Dr Marcus, is on the practical, hands-on issue that medical offices confront routinely in the treatment of injured worker The booklet was developed to give practical assistance to physicians and thei office staffs who occasionally treat injured workers and find themselves wad ing through the maze of new regulations.

The booklet was prepared by TMA's Ad Hoc Committee on the Worker Compensation Fee Guideline under the chairmanship of Ray E. Santos, MD.

The reform of workers' compensation laws in Texas was designed to ad dress a "crisis" in the affordability of insurance coverage that was making th state less attractive as a site for economic development. The Texas Worker Compensation Commission — the regulatory agency created to replace th Industrial Accident Board that had previously administered the program — has pursued medical cost containment as a primary method of reducing cost for Texas employers.

Those cost-cutting efforts have dropped a combined burden of reduce fees, increased paperwork, and a maze of new utilization review and man aged care requirements squarely in the laps of physicians.

The booklet costs $35 for TMA members, $70 for nonmembers. For mor information, or to order the booklet, contact TMA Practice Management Ser vices at (800) 880-1300 or (512) 370-1422.

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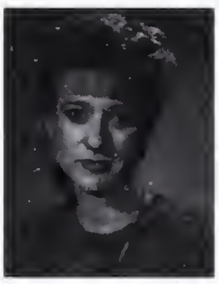

Deborah Brasier

Daniel Burn

John Fredricksen

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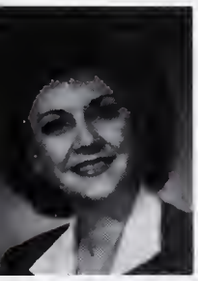
Kermit R. Hoover, Jr.



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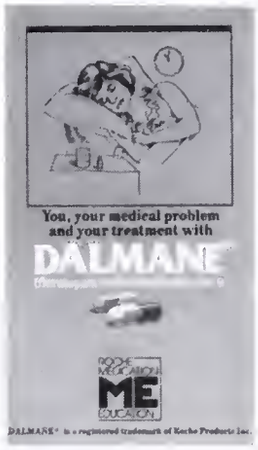

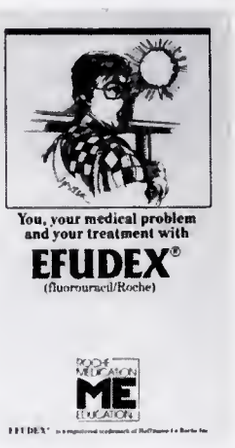

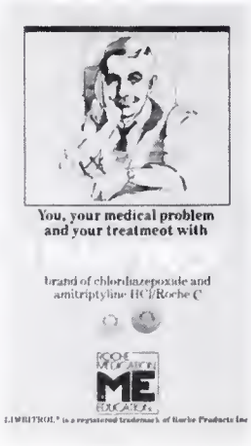

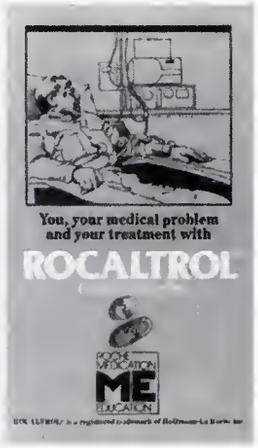

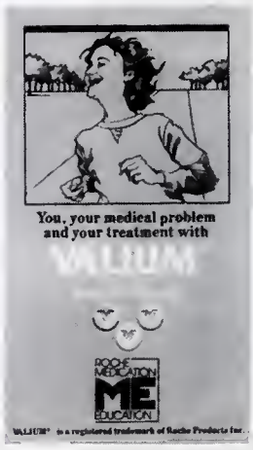

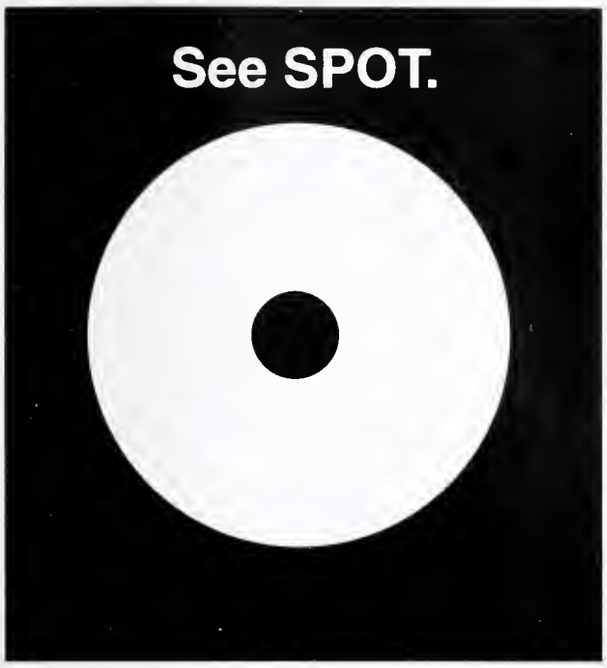

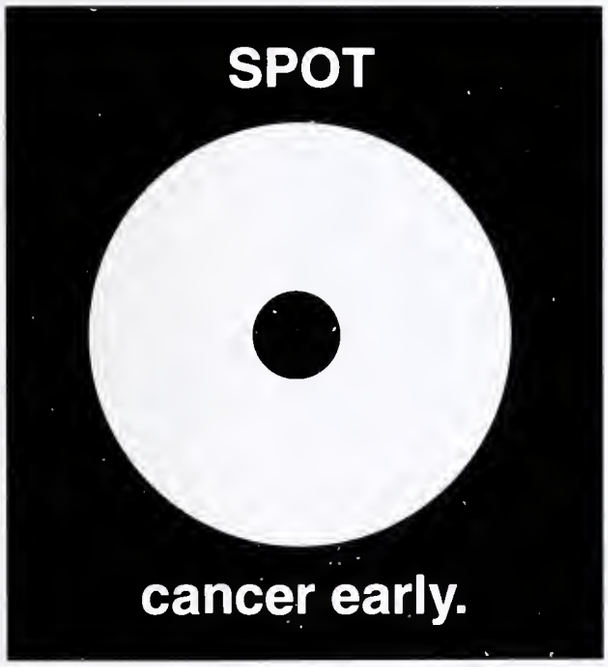

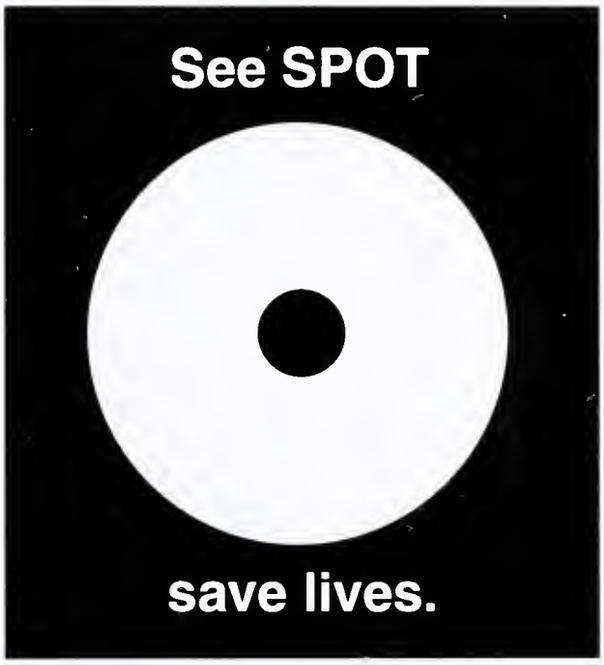

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RBRVS. OSHA. CLIA. What next? Dubbed "the year of regulatory overload," 1992 has seen the birth and explosive growth of more stipulations, regulations, aggravations, and outright

THE VOICE OF MEDICINE

Who is listening?

interference in the private practice of medicine than ever before. Embattled physicians are wondering who is strong enough to reverse this destructive trend and return some sanity — and enjoyment — to medical practice.

KATHRYN TROMBATORE, MANAGING EDITOR

No profession in America is more regulated, legislated, watched, and second-guessed than physicians.

Perhaps because medicine touches so many people so intimately — holds such hope and such terror — society has tried to insist, in every possible legislative and regulatory way, on the mutually exclusive trinity of perfection, immediate availability, and affordability.

As the United States lurches toward some sort of national health policy, lured, possibly, by the desperate wish that controlling health-care costs will somehow control sickness and death, physicians' opinions on health policy are difficult to hear above the din of political sound bites. The medical profession's need to retain a position of influence in the debate has never been stronger, and yet some fear that the diversity of opinion within the medical community has weakened its voice.

But to others, physicians' tendency toward independent thinking represents one of the profession's great strengths that can help them gain the respect of lawmakers and regulators.

Both in Texas and at the national level, one good thing may result from the intense controversy about health-care policy: more physicians may be enticed into participating actively in the political process. And that, say "doctor watchers," can help return responsibility for the medical profession to physicians.

FINDING YOUR VOICE

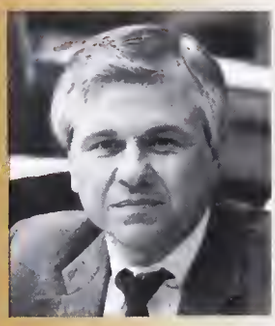
"Everybody says, 'Oh, I don't have time for politics; I'm too busy,'" complains Mike McKinney, MD, former state representative and newly appointed member of the Congressional Physician Payment Review Commission. "I've got news for them. You're involved in politics. If you practice medicine in Texas, you're involved in politics."

The same is true in spades at the national level.

"Congress has almost as much to say about practicing medicine as medical journals do," says Nancy Dickey, MD, Richmond, member of the American Medical Association Board of Trustees. "The legislators are involved in HIV testing, the legislators are involved in living wills, the legislators are involved in whether or not I can offer particular kinds of treatment."

"If you practice medicine in Texas, you're involved in politics."

— Mike McKinney, MD



"Congress has almost as much to say about practicing medicine as medical journals do."

—Nancy Dickey, MD

But, despite the degree to which they regulate medical practice, those policymakers aren't always very knowledgeable about medicine.

"Some of them have yet to embrace germ theory as an origin of disease," laughs Texas Medical Association lobbyist Kim Ross. "But they can persuade votes, and they must be taken very seriously.

"Take, for instance, the situation we face in Texas. The entire Texas legislature is up for election this year. And those 181 legislators will, in effect, be required by law to rewrite the Medical Practice Act and every single law governing the practice of medicine in 1993. The legislators get to play doctor next year, and unless we get ourselves involved in the political process right now, they may very well elevate a nonphysician to the equivalent of a neurosurgeon."

Despite Mr Ross's plea for increased involvement, Texas physicians haven't done badly in their legislative efforts in recent years — a fact so well known that public officials, physicians, and consultants alike line up to pay tribute to TMA's influence.

"I wouldn't be on the Texas Supreme Court if it wasn't for the help that the medical community gave me," says Justice John Cornyn, who was elected in 1990.

Elections to the court that year expanded what had been one of TMA's biggest political triumphs, when it helped engineer a major shift in the composition of the court in 1988.

"The Supreme Court races of 1988 and 1990 were great demonstrations of medicine's ability to really make a difference," says William G. Gamel, MD, Austin, who will be installed May 16 as TMA president. "We led the way for the whole state — for the legal profession, for business, for insurance, for everybody. It was the doctors in their offices talking to patients and handing out cards — and their spouses running phone banks and block walks and putting up signs — that had the decisive effect."

Another lawmaker who praises Texas doctors is Frank Tejeda (D-San Antonio). "Quite frankly, I would not be where I'm at today, a state senator, nor would I be a Congressional candidate, were it not for doctors, were it not for their involvement," he says.

But helping elect public officials is just one step in a never-ending cycle. Once legislators are elected, medicine must maintain ties with them, educating them about the needs of pa-

tients and physicians, and helping research, draft, and enact legislation, or block or amend poorly drawn or badly conceived legislation.

Success on that front, however, demands something different in the 1990s than the strategies that worked with yesteryear's "good ole boys."

CLOUT 101

"The days of the crude display of raw power are behind us in the new Texas," says George C. Shipley, PhD, president of Shipley & Associates, Inc, a public opinion research and consulting group, and consultant to TMA.

Instead, he says, the slow, meticulous building of relationships, carefully chosen across a broad spectrum of interests, provides the firmest foundation for long-term political strength.

"In the 6 years I've worked with TMA, the organization has dramatically improved its political posture," says Dr Shipley. "It has become overtly bipartisan — something it needed to become — and it's become more responsive to different kinds of political ears. We have forged new alliances, particularly with the Hispanic and black communities.

"As a result, we are clearly at the seat of power. We are there, however, not because we have forced our way there, but because we have been asked to come to the table," he says. "And we will keep our seat as long as we remember that we are one voice among many and that we do not have exclusive claim to the truth, in the minds of public officials. But medicine will fail if we permit ourselves to be manipulated by special interest groups or by a single political party or by those who have ideological axes to sharpen." (So closely does Dr Shipley, who was one of Gov Ann Richards' chief consultants during her campaign, align himself with his physician-clients that he speaks in terms of "we" when discussing what medicine needs to do to maintain its political force.)

Both Dr Shipley and TMA legislative director Alfred Gilchrist stress that TMA understands the importance of two cardinal laws of politics: asking only for what is doable and maintaining loyalty.

"Politics *is* people," says Mr Gilchrist, "friends helping friends, and forgiving them their errors and differences. Loyalty is a two-way street, but loyalty has limits. We cannot ask public officials to do things that are selfish or self-destructive, nor can we ask them to do things that are not in the public interest. We also cannot expect others to reciprocate with any more loyalty than we ourselves have demonstrated."

Strengthening those loyalties across the broadest possible base is what TMA has concentrated on in the last few years.

Mr Gilchrist says, "Being able to work with such "left of center" groups as the Children's Defense Fund, the People First organization, and even, on occasion, the Texas Trial Lawyers Association, when their stance on a public health issue coincides with that of the medical profession, enhances medicine's credibility, increases cooperatic and reduces the possibility of poli cal ambush."

The same principle is true Washington, says James S. Tod MD, executive vice president of t AMA. "Power politics might ha worked once, but today's proble are so awesome that drawing a l in the sand serves no one well."

Coalition building — creati new nontraditional alliances alo with long-standing conservative t — is a dominant political strate for today's medical federation.

But it is the ability to comprom that is the surest gu antee of victory, a that sometimes caus problems for phys cians who have a ha time accepting part success, says Dr Tod

"Part of t difficulty with phys cians is that they a used to good resul total results in the practices," he say "Anything other th that is a blot on the performance and u sets them no end. B when you get into t political arena, politi is the art of the pos ble. You never get everything you wa in politics, nor should you expect to.'

Despite the reality of compromi and partial success, TMA lobbyi Kim Ross says Texas physicians ha plenty of reason to be proud of the organization's political prowess. "O reputation in Washington and wi other state medical associatio around the country is that we are t model. We're what they envy, wh everybody else wishes they could be.

"We have had a powerful effec The laws that wouldn't be on t books without us run the gam from the motorcycle helmet law t utilization review reform, to low liability premiums as a result HB18, major rural health initiative AIDS policy, organ transplant legi lation, and trauma care laws."

"Every single law governing the practice of medicine in Texas will be rewritten next year . . ."

— Kim Ross, TMA director of public affairs

"The days of the crude display of raw power are behind us in the new Texas."

—George C. Shipley, PhD

WIDENING THE AGENDA

TMA's recent political success has come, in large measure, because it expanded its legislative focus to include ublic health issues and greatly in-eased the number of groups with hich it carries on dialogue.

Dr Shipley says, "Medicine has hanged to a pragmatic approach hat recognizes that decisions are ammered out by compromise, that ot all battles carry a partisan tinge."

Today's coalition building some-mes makes for partnerships that ould have been un-hinkable a decade go, and it is ifficult for some hysicians to realize, ays Dr Shipley, that he battles medicine hust wage in the 990s are no longer xclusively with the ich trial lawyers.

Instead, the ef-orts to expand ac-ess to health care, o deal with prob-ems such as indi-ent health care, IDS, and the roader questions of ublic health call for hore negotiation han muscle flexing.

"If TMA is the champion of hysicians' patients," says Mr Ross, if we are the advocates of im-roved levels of health care for the ntire population, then we are more redible than if we were simply ar-uing for, say, malpractice relief."

Dr Shipley concurs: "No one will hed a tear for the wealthy doctor. There are those who frankly resent he amount of money that doctors ap-ear to make. We cannot expect the ublic to have empathy with us if all ve do is display narrow self-interest.

"If we take the philosophy that we articipate in politics almost as a orm of public service, where we are helping people, and that we are advo-ates, not of wealth and power, but of mproved access to health care, then I hink we will be listened to on our other, more abstract issues."

By way of example, Mr Gilchrist talks about physicians' continuing interest in tort reform. He describes the "liability Beirut" that exists in the Rio Grande Valley and how difficult it is for some physicians to understand "why we're not down there with a bucket to put out the fire."

But, he says, from the polls of physicians statewide, TMA lobbyists know that the liability issue is one of five or six of equal and competing priority and that exclusively focusing on one issue is a sure way to lose.

"We are not for a moment counseling appeasement," Mr Ross cautions, "nor are we abandoning our interest in the healthy reform of liability laws in Texas. The problem is that politics is a game of coalition building and in order to build coalitions on insurance reform or public health or stopping the nonmedical practice of medicine, we cannot scorch the earth and burn bridges with potential allies. We do so only at peril to ourselves.

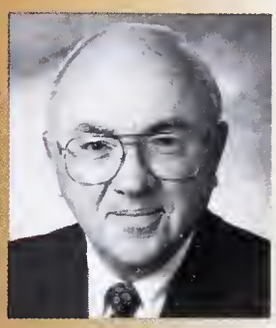
"The most important steps in liability reform are in the election process, both in the Senate and the Supreme Court. Medicine helped win some major victories in the March '92 primaries — for example, Senator Lucio in the Valley, Senator Sims in West Texas, and Justices Enoch and Hightower in the court.

"But if we take a one-dimensional viewpoint — that we are locked in this eternal struggle with philosophic adversaries on the medical malpractice question, and only that question — we invite attack from psychologists and chiropractors, nurse practitioners, and all the other individuals who would like the legislature to turn them into physicians."

"The lessons here are those of political sophistication, of dialogue as opposed to raw muscle," says Dr Shipley, who polls extensively on behalf of TMA and the Texas Medical Association Political Action Committee (TEXPAC). "I don't think it's fair any longer to talk about clout in a macho, controlling way. I think the policymakers resent it and I know the public resents it."

"It's our patients who can save medicine, because they cast the votes and elect the politicians."

— **William G. Gamel, MD, TMA President-Elect**



"We cannot ask public officials to do things that are selfish or self-destructive."

— **Alfred Gilchrist, TMA Director of Legislative Affairs**

"PHYSICIANS WOULD CONTROL THE WORLD . . ."

Given that flourishing in the political world now requires a level of adroitness and finesse that even long-time lobbyists practice hard to retain, physicians may think themselves ill-equipped for a role in furthering the interests of the profession.

However, one traditional political strategy has become even more critical in the 1990s: grassroots activity.

"The beauty of democracy is that anyone can play," says Valerie Terry, TMA's director of political education and TEXPAC treasurer. "The tragedy is that so few take the time. The issue is that no matter how good your lobbyists and consultants are, you cannot buy, manipulate, coerce, or engineer democracy. The key is participation. That's the step to empowerment."

A recent vigorous effort by the nation's physicians demonstrated the force that the medical federation can have. After HCFA's release last June of its proposed rules for implementing the new Medicare Resource-Based

IT'S A SAFE BET that few physicians suffer from having too much time on their hands. And even fewer are inclined to spend spare moments running candidate-support phone banks or stuffing campaign materials into envelopes.

But there is another way that physicians can make their voices heard in the political process.

Membership in TEXPAC, the Texas Medical Association Political Action Committee, says Valerie Terry, its treasurer and also TMA director of political education, is the best way for physicians to be involved.

"TEXPAC is set up specifically to represent all those physicians who don't have time," she says, although the organization also welcomes those who can set up one-to-one relationships with legislators, throw fundraisers, or sign letters of support for candidates. "Doctors' financial contributions make an enormous difference and it only takes seconds to write a check that provides vital support."

"By coming together in TEXPAC, we magnify our voices."
— SAM A. NIXON, MD, TMA PRESIDENT

TEXPAC has two primary functions. As a political action committee, the funds it collects are used to support candidates for political office. Candidates are evaluated for potential support based on local physician/auxilian recommendations, formulated from interviews they hold directly with the candidates via their county medical societies, in addition to prior knowledge of candidates. Candidates' estimated "winnability," and, in the case of incumbents, previous voting records are strongly considered.

TEXPAC's candidate evaluation committee is chaired by Sheldon Gross, MD, San Antonio, and overseen by the TEXPAC board of directors, chaired by Richard Stoebner, MD, San Angelo. The board consists of a physician from each of the 31 state senatorial districts, four members of the TMA Auxiliary, and a resident physician and medical student. Assisting the board are vice chairs from each of the 31 districts. The board endorses candidates and directs the level of financial support TEXPAC provides to candidates for the Texas House of Representatives and Senate, and decides to which of Texas' Congressional candidates the AMA's political action committee, AMPAC, provides resources.

The second TEXPAC mission, says Ms Terry, is to motivate physicians and auxilians to participate in the political process and to educate them about which candidates to support. TEXPAC's grassroots organization is unsurpassed among state medical associations.

Formed in 1962, just a year after AMPAC, TEXPAC is one of the largest bipartisan political action committees in Texas and in the top 10 business and professional PACs in the country.

Its success in recent years, logged on what is known as a "candidate support track record," is phenomenal. In 1990 TEXPAC achieved a 95% win rate in 80 separate races (Only a couple of special elections were held in 1991, and TEXPAC was virtually 100% in those.) The PAC has steadily increased its win rate from 77% in 1982.

Despite that success, only about one in three Texas physicians currently supports TEXPAC, and that third, says Dr Stoebner, have carried the ball for the rest of the state.

"I can't overemphasize how much we appreciate the continued involvement of the tried and true," he says. "Many of the good things that have happened to the medical profession in Texas have been because of this small group of people who have been the crusaders."

But as 1993 — the year of the sunset review of the Medical Practice Act — approaches, involvement by a larger percentage of Texas physicians would greatly bolster TEXPAC's strength and physicians' voice in the political and legislative process, says Ms Terry.

Membership in TEXPAC is open to TMA members and their spouses. (See the ad on p 46). For physicians, membership categories include the 300 Club (for a contribution of $300), active membership (for $100), and advocate membership (open to first-year practitioners and retired physicians only for a contribution of $45). Membership for residents is $20 and medical students may participate for free. Auxiliary membership categories include the 300 Club (a contribution of $300, or $500 for joint physician and spouse), Auxiliary sustaining membership ($100), and Auxiliary active ($35). There is also a free category for spouses of residents and medical students.

Checks should be made payable to TEXPAC and mailed to TEXPAC at 401 W 15th St, Austin, TX 78701. For further information, TMA members may call (800) 880-1300 or (512) 370-1363.

Contributions to Texas Medical Association PAC (TEXPAC), Texas Medical Association PAC-Statewide (TEXPAC-Statewide), and American Medical Association PAC (AMPAC) are not deductible as charitable contributions for federal income tax purposes.

Voluntary political contributions to TEXPAC are shared with AMPAC. Contributions are not limited to the suggested amount. Neither TMA nor AMA will favor or disadvantage anyone based on the amounts or failure to make contributions. Contributions to TEXPAC and AMPAC are subject to Federal Election Commission regulations. Federal election law prohibits TMA from soliciting donations from persons who are not in its solicitable class (eg, TMA members and their families). All donations received from persons who are not in TMA's solicitable class will be returned.

elative Value Scale (RBRVS), doctors nt almost 100,000 furious letters of rotest directly to HCFA. And unounted thousands were mailed to invidual legislators. The result?

"We got $10 billion back out of a overnment deep in red ink," says r Todd.

That success, and the more rent amelioration in the Clinical aboratory Improvement Act anks to 60,000 letters to HCFA, emonstrates how much physicians an accomplish.

Writing letters to regulators and egislators isn't, however, what any see as the ost potent way for hysicians to regain me control over e regulation of eir profession.

"Physicians ould control the orld if they talked o their patients," ys Dr Todd. "Four illion patients a ay walk into physians' offices."

Educating those tients about healthre policy, about the sues facing the medal profession will elp make them more ware that physicians' concerns and terests are not just self-serving, says coming TMA President William amel, who describes the medical rofession as a "sleeping giant."

"I have a basic premise that docrs can't save medicine," he says. It's our patients who can save edicine, because they cast the votes nd elect the politicians. And politians are always going to listen to the lectorate."

Physicians who take the time to xplain to patients the problems ith Medicare and the other ifficulties the medical profession aces and who let patients see them truggling with the hassles and paerwork present a more genuine, oncerned face to their patients.

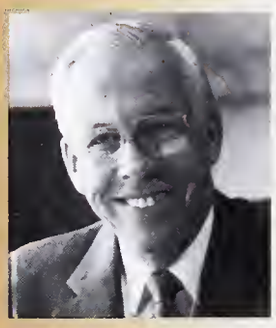
That message, however, must be elivered not as a complaint from physicians about their wretched working conditions, but as a plea for patients' help in protecting the quality of medical care that Americans take for granted, says Bryan Eppstein, president of the Fort Worth-based Eppstein Group, a Republican-oriented firm, and a political consultant to TMA since 1986.

"Doctors need to let their patients know that they [the patients] have a good thing, and if you take a good thing for granted it will be taken away from you," says Mr Eppstein. "Doctors need to say to patients, 'You know, there are some problems with medicine and some things we can do together to fix those problems.'

"Instead of the spokesperson for physicians being the AMA," he continues, "it needs to be an 'AAPP'—American Association of Physicians and Patients. There needs to be more camaraderie between physicians and patients, less of a relationship of provider to customer."

"Physicians would control the world if they talked to their patients."

— JAMES S. TODD, MD, AMA EXECUTIVE VICE PRESIDENT



"There needs to be more camaraderie between physicians and patients, less of a relationship of provider to customer."

— BRYAN EPPSTEIN

DISAGREEING, BUT STAYING TOGETHER

Although Mr Eppstein is not really serious about recommending that the AMA be replaced by an AAPP, he and others have voiced concerns about medicine's ability to retain sufficient cohesiveness as a group to be heard.

And doing so without appearing to present an "us against them" stance is an even greater challenge.

"I think that if the AMA really wants to have an effect, it has to quit letting itself be the victim of political polarization, where you're either on one side or the other," says Mr Eppstein.

What Congress and the press have done, he says, is place the medical profession in a very negative position by presenting the battle to contain health-care costs as a choice between doctors getting rich and patients having lower medical bills.

Combine that perception with lawmakers' charge that the AMA's representation of fewer than 50% of American physicians is reason not to take the organization's message seriously, and the medical federation is in real need of revitalization.

"Until the AMA represents a majority of its self-proclaimed constituency, it won't be as effective as physicians across the country would like it to be," said US Rep Charles W. Stenholm (D-Tex) in a 1989 interview. Today, although the AMA's total number of members has grown, its market share is still only about 41% and it has launched a major campaign to reach the longed-for 50%.

James Todd, MD, has spent much time since being appointed AMA executive vice president in 1990 speaking eloquently for participation in the organization.

"I take as an enemy anybody who tries to dilute the strength of the AMA," he says. "There is no other organization in the country that can do what the AMA can do if it is given the support and the resources it needs to do the job."

But "umbrella organizations" or, as Dr Todd prefers the AMA to be known, "foundation organizations" increasingly find themselves mediat-

ing between subgroups of their members. Playing that role can make it difficult for an organization to maintain the kind of market share that it needs.

The AMA did, however, mostly avert the even greater threat of being bypassed completely by specialty groups eager to improve their lot under RBRVS through direct negotiation with lawmakers. The much-feared total splintering of the federation was avoided only by skillful balancing of differences.

Says TMA lobbyist Kim Ross, "The AMA Washington office's management of the specialty societies during RBRVS during that crucial last session of Congress was superb because they kept everybody in the room, at the table, talking to each other so that those among the specialty societies inclined to use undermining tactics really couldn't get away with it. The AMA's use of peer pressure was masterful."

No one disagrees that smaller, more specialized organizations — like county, state, or specialty societies — have a tightness of focus that makes them attractive to members, but the cohesiveness within smaller organizations cannot replace the force of larger, more broadly based coalitions.

"The disadvantage of the generic medical organization is that it has to consider everything, to try to be all things to all people," says Robert G. Mickey, TMA executive vice president. "However, the specialty organizations are at real disadvantages when they get into economic business of an all-win, all-lose nature.

"The AMA has a distinct role to play that nobody else can. The troublesome thing is most doctors who don't support the AMA don't understand its role. They don't realize that the medical federation is a triad in which neither state nor county societies can possibly do what the AMA does."

Dr Todd seems to accept with only a trace of sadness the fact that unity is not easily achieved. "The parochialism of the states and the specialty societies, who of necessity see problems that affect them and not the rest of the physician population, is just one of the defects of the system," he says. "But, recognizing that, we have to find those overarching areas — such as health-care reform — that are bigger than any of us and cooperate on those. We need to work on our areas of disagreement very quietly within our organization and not let our dirty linen hang out."

He adds that it's not a matter of *whether* the various segments of the profession can work together: "I would say they *have* to work together or medicine will be so divided that it will be easily conquered. We've had ample examples of that already. I use the analogy of the AMA as the foundation upon which we build the house of medicine. Every room will be different (the state societies and the specialty societies), but it is the edifice of medicine that the outside world will see."

"It's *our* AMA, not *the* AMA."

— Harris M. Hauser, MD

"The AMA is an excruciatingly democratic organization."

— Susan Rudd Wynn, MD

COMMUNICATION: AN IMPOSSIBLE TASK

Convincing its more tha 300,000 members eac year of the value of the dues is perhaps th AMA's greatest challenge.

And given the fact that phys cians have little time to read even e sential information (and less inclin tion to read what they may see merely advertisement), the AMA is tough sell.

"A lot of the things that th AMA does don't necessarily com across well on paper, says Susan Rud Wynn, MD, Fo Worth allergist, TM alternate delegate t the AMA, and chai of the TMA Counc on Communicatio And that's why, sh says, Dr John Do who has never been t an AMA meeting ha such a difficult tim seeing that he's gettin his money's worth.

TMA President elect Gamel agrees. " think the AMA suffe from a lack of loca identity," he says. " lot of what the AM does is just not visible."

But that doesn't mean it isn' valuable. Most physicians don't un derstand the critical role that th AMA plays in many areas, particu larly in science, medical educatio and public health, says TMA's M Mickey, and they consider only thei perception of the AMA's success o failure on medical economic issues.

"And so if the AMA is not suc cessful on an individual economic is sue," he says, "and virtually no pri vate organization can be consistentl successful anymore with Congres then a growing number of physician view that as a loss of value, and reac by dropping their membership."

He (and others) wish the AM could do a better job of communi cating its value to members (an nonmembers), but no one ha

und the secret to getting doctors listen to messages they may not ıve time to hear.

"The further away you are from mebody, the more difficult it is to ɔmmunicate how you're being of ɛlp to them," says Mr Mickey. TMA and county societies have the lvantage of communicating about calized programs and activities.

"But none of us has done a good ıough job of communicating to ıysicians the value of the AMA."

Some physicians suspect their ɔlleagues are venting their frustra- ɔn about the decreasing amount of ɔntrol they have over their own ofession by dropping their mem- ɛrship in organized medicine.

Getting mad at an organization is sier, they say, than facing up to the nount of societal change that is af- cting physicians.

"Our constituency has to realize at they can't have everything as it's ɛen," says Dr Todd. "We do not and still in time. The problems are fferent, solutions are more limited, ıd the medical profession has to be part of change or they're going to ɛ left behind."

Responding to physicians who ɔmplain that the AMA hasn't been ɔle to stop this or that regulation aggravation, Dr Wynn says, "It's ırd to prove a negative, so it's hard convince physicians that they are ally much better off for having the MA. I think we have to constantly mind physicians of what we would ıve if the AMA weren't there. We ould already have mandatory as- gnment. We would already have RGs for physicians. The RBRVS robably never would have come ɔout because something else would ave happened a long time ago that ould have been much worse."

"EXCRUCIATINGLY DEMOCRATIC"

Another argument against participation in the AMA is the charge that it's still a "good ole boy's club" in hich only the privileged few can re- lly participate. To which Dr Wynn ɛtorts, "The AMA is an excruciatingly democratic organization." After 13 years of involvement with the AMA, she's in a position to know.

Her partner, Bob Lanier, MD, agrees.

In the February 1992 issue of the *Tarrant County Physician*, he wrote:

"No one has been more critical of the good ole boys of the American *Mediocre* Association than I. In my frustration with the Jello movement of medicine in times of crisis, I have used the terms dinosaurial, archaic, unwieldy, constipated, and impotent in some of my more generous moments."

But thanks to his role as an "AMA rookie" (he served as an alternate delegate from a specialty society), he had a conversion experience:

"It was with more than a few crow feathers sticking to my lips that I sat through exhausting and often passionate debates. I always thought the AMA position papers came out of sedate committees who

TALKING TEXAS AT THE AMA

TEXAS HAS LONG BEEN A POWER with which to reckon at the AMA. Today is no different.

More than 95 Texas physicians and medical students held positions of leadership within the AMA organizational structure during 1991.

Joseph T. Painter, MD, Houston, is chairman of the AMA Board of Trustees, and Nancy Dickey, MD, Richmond, is a member of the board and of its executive committee.

Forty delegates and alternate delegates represent TMA in the AMA House of Delegates, and other Texas physicians represent specialty societies or serve as members and leaders of AMA sections, councils, committees, or on editorial boards of AMA specialty journals.

The Texas delegation to the AMA House is widely regarded as a very strong, conservative voice.

Susan Rudd Wynn, MD, a TMA alternate delegate, originally had an outsider's view of that strength.

During 6 years of living in Minnesota and being involved in the AMA, she realized "that one of the things people have tended to criticize the Texas delegation for, which is the fact that it never changes, is what made it so strong.

"You could count on those guys, rain or shine," says Dr Wynn. "They were there, you knew how they felt, they were well organized, they had done their homework, they had a fabulous support staff, and they had confidence and strength."

Striking a balance between maintaining that political strength and opening the delegation up to younger members is the challenge that TMA faces, says Dr Wynn.

The three newest alternate delegates are young, female physicians. Dr Wynn was elected in 1991, the same year in which TMA President Sam A. Nixon, MD, Houston, appointed Houston psychiatrist Priscilla Ray, MD, and Dallas pediatrician Carolyn Evans, MD, to fill vacancies. At the TMA House of Delegates meeting in San Antonio this month, Drs Ray and Evans stand for election to their seats on the delegation, and Dr Wynn stands for reelection.

Preserving the strength of TMA's delegation to the AMA also rests on the percentage of TMA members who are AMA members. Currently only 56% are AMA members, down almost 40% from the peak in the 1960s.

To AMA Executive Vice President James Todd, MD, that's just not good enough. "Every physician ought to participate in the affairs of their profession," he says. "It's no longer satisfactory just to be a good physician. Every physician has a responsibility to do everything they can to make sure that the physicians who come after them have the same opportunities that they now enjoy. And the only way to do that is to multiply the talents and resources available by joining with organized medicine. The full strength of organized medicine will not be reached until every physician in this country participates."

rubber-stamped staff recommendations, but it ain't true. The good ole boys don't mind taking off the gloves," he wrote.

Another vocal champion of the AMA is Houston neurologist Harris M. Hauser, MD, a special advisor to the TMA Committee on Membership. His conversion came about during a trip he made to Chicago with his wife, who was a delegate to the AMA Auxiliary.

Dr Hauser went over to investigate the AMA House of Delegates and was surprised by the degree to which he was made to feel at home, encouraged to speak up at reference committees, and urged to get involved in the process.

He was impressed, too, with the amount of work each delegate does. (Dr Lanier claims that whole forests are logged for a single AMA meeting.)

"I left there thinking, you know, we've been critical of our delegates, but we really need to give them some support," says Dr Hauser.

Dr Hauser now refers not to *the* AMA, but to *our* AMA. The sense of ownership is important, he says, to remind physicians that if they are dissatisfied with something about the organization, they must speak up.

"I've now started referring to *our* AMA whether I'm talking to a member or nonmember, because nonmembers are just nonsupporting, non-dues-paying members," says Dr Hauser. "But if you really want to be heard, pay your dues."

NOT EVERYONE AGREES

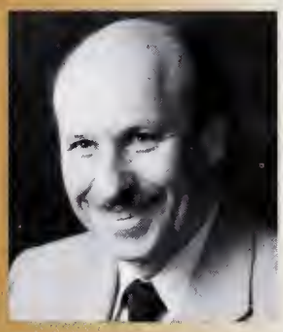
One physician who has steadfastly maintained his membership in both the AMA and TMA is, nonetheless, extremely frustrated with what he sees happening to the medical profession and less than thrilled about the federation's response.

San Antonio oncologist Stephen C. Cohen, MD, a former president of the Bexar County Medical Society, believes organized medicine — and individual physicians — have abdicated their responsibility for medicine by letting nonphysicians dictate how medicine gets practiced.

"As long as doctors don't fight back, this interference is going to continue," he says. "I call this gestapo care. I envision a day when someone will pick up a doctor at his house and drive him to work and stay with him all day and all night and help participate in every decision he makes."

"As long as doctors don't fight back, this interference is going to continue."

— Stephen C. Cohen, MD



"We as leaders need to listen better . . . "

— Neal H. Gray, MD

The solution?

He advocates a number of measures, some more palatable to his colleagues than others. First, he calls for "what Martin Luther King did in the 60s — passive resistance." He *never,* he says, cooperates with what he sees as inappropriate involvement by outsiders. As an example, he recently replied to one utilization review request by sending a color photograph of a patient with eye cancer as his sole response, defying them, he said, not to pay the claim.

A second method of combating unwanted interference is a favorite of the organization Physicians Who Care, which Dr Cohen helped found in 1985. The group counts as members about 400 San Antonio physicians and a few thousand national Dr Cohen says its members regular send postcards to government officia and others whenever they do som thing that is destructive to medicine.

Dr Cohen, who is openly critic of physicians who participate managed care settings, knows th his third recommendation for i proving the medical profession w draw criticism. "I really believe t only way we're going to deal wi the problems is if organiz medicine gets on the stick," he sa "Because one of our problems that we have such a diversity of i terests, I think t AMA and the TM have got to aband the group of docto who are not in priva practice. They cann represent every do tor, in my opinion."

But leaving out ac demic physicians, mi tary physicians, ar physicians just becau they don't participa in traditional fee-fo service practice is e actly the wrong a proach, says curre Bexar County Medic Society President Ne H. Gray, MD, an ane thesiologist.

"I think that a lot of the pro lems that we have as leaders and medical societies come because w really aren't listening very careful to these fractionated groups physicians and have not been able really identify those areas that the groups have in common and then work on that," says Dr Gray. "F instance, we have a large section young physicians who are movi almost immediately after graduati into some sort of managed car This is foreign to many of the old physicians, and they don't really u derstand the problems that the co tract physician is working under. W as leaders need to listen better those folks and to understand wha happening to them because they d serve our support too."

He adds that, in like manner, developing avenues for participation y academic physicians, military hysicians, female physicians, residents, international medical gradutes, and other identifiable groups is hat leadership is all about.

To Fort Worth allergist Dr Wynn, ıvolving those groups is more than ıst a public relations issue. "There re important ideas and important ılents out there that need to be put) use throughout organized ıedicine," she says.

The AMA's Dr Todd bristles at the ıggestion that only fee-for-service hysicians deserve epresentation.

"Why do they ıink fee-for-service is ıe only method by hich to deliver ealth care?" he asks. Some of their colagues, just as dediated and ideological s they are, have deded that HMOs and roup practices preent an opportunity to rovide good medical ıre under different rcumstances.

"We talk about eedom of choice for atients. We also ught to be talking about freedom f choice for physicians. If you want) practice in a group, an HMO or a PO, or private fee-for-service, you ıould be able to do that unfettered y criticism other than that directed t issues of quality and cost."

Dr Todd also doesn't necessarily gree that all so-called interference ı medicine is bad.

"The physician who wants to ractice unfettered, who doesn't want ny of these intrusions, has to realize ıat today physicians can do as much arm as good in a fraction of a secnd. Therefore, the public wants docmented competence and accountabily. And, if this can be done — and it ıould be done less intrusively than it now — as professionals, it should e a challenge physicians welcome."

Historically, TMA has been a fee-for-service champion, says TMA President-elect Gamel. But, he says, "Economic forces are having a tremendous impact on medicine. The traditional fee-for-service medicine that I grew up with is becoming less and less of the part of the health-care delivery system.

"There's going to be a pluralistic system of health-care delivery, and I don't think that we can be in denial over that. I think the system probably will involve something that no one will be 100% satisfied with, but it's coming. And we need to be at the table to help shape that. I hope and pray that we maintain freedom of choice for our patients."

TMA President Sam A. Nixon, MD, Houston, whose term of office ends this month, reiterates that there's room for everyone: "Organized medicine is open to physicians from every type of practice. Certainly we have disagreements and problems, but the TMA and the AMA offer the arenas and the processes to address those differences and to arrive at common grounds of agreement and cooperation. We need to use those processes."

Ironing out disagreements, however, doesn't mean that all physicians must ultimately adopt the same posture, points out Houston neurologist Dr Hauser, who cautions that pleas for unity sometimes draw responses like, "Well, I don't want to be in the same boat with that guy over there. His ideas are off-base."

Instead, Dr Hauser says, "I don't think we need to be united. What we need is for everyone to be a participant."

"The doctors are not *our* members. We are *their* staff."

— Robert G. Mickey, TMA executive vice president

"The medical federation makes it possible for physicians to multiply their efforts."

— Robin Weinman, executive director, El Paso County Medical Society

TMA: WILLING TO RISK

It is obvious from the numbers that Texas physicians are generally pleased with their state medical association. TMA enjoys a very healthy market share (83% of the licensed, practicing MDs in Texas are TMA members), and the trend is stable, unlike the drop in membership being felt by medical organizations in many other states.

TMA Executive Vice President Mickey attributes TMA's success both to a history of "professional bonding" in Texas and to hard work.

"I think there's a stronger sense of bonding in Texas than in some other states," he says. "We don't have as many cultural differences within Texas. The people in the Valley and the people in the Panhandle and in east and west Texas have unique approaches to things but we have a feeling of belonging to the state, and I think that is reflected in physicians. There's probably more agreement on policy and programs in Texas than there is in other so-called progressive states, such as California.

"Additionally, TMA has always been a very active and aggressive organization and I think that's appreciated by those who support it financially. We've always had a certain boldness that perhaps other states have not had."

Despite his obvious pride in TMA's strength, Mr Mickey quickly turns worried when talk centers on the loss of members that other state organizations, and the AMA, have faced.

"I think we're vulnerable, too,"

he says. "We have to work harder now to stay even. Doctors feel that way about their practice, so we shouldn't be surprised if it's reflected in their organization.

"TMA has never coasted, to its great credit. And if it chose to coast now it would be suicidal. There are more issues, more problems, more demands, more expectations by doctors than ever before. We are increasingly putting the organization on the line."

But it's not enough, he says, to just keep adding activities.

"We have to have success. We can't just say, look how much we're doing. The question is: How well are we doing it? We have to keep quality and success built into the program."

That's right, says Dr Hauser. Busyness for busyness' sake is no good. When asked about whether just the act of participating in organized medicine might make physicians *feel* better about themselves and their profession, even if no conclusive improvements occur, Dr Hauser minces no words: "I ain't doing this to feel good. I hope to make a difference. I want change."

THE REAL BOTTOM LINE

Giving a straight answer to physicians who want to know just exactly what it is that they get from organized medicine is important to Robin Weinman, executive director of the El Paso County Medical Society, who says she hates answers to that question that list general membership benefits.

She recounts, instead, a wealth of specifics. Among them:

"Any individual physician who didn't meet with his congressman three times last year should be very pleased that his colleagues did that for him. And a doctor who has never had the chance to be interviewed for a news story should be glad that his public relations committee here coordinates a weekly TV program, a weekly newspaper article. A doctor who didn't have a chance to meet with representatives of the AARP ought to be very glad that a few colleagues took the time to build that liaison. What the society does is make it possible for those few doctors who *can* take a community role on behalf of their colleagues to do it efficiently and effectively. We make it possible for them to multiply their efforts."

In short, as TMA's current membership recruitment brochure states, "You could hire your own personal staff of lawyers, researchers, lobbyists, and public relations experts . . . or, you could take advantage of ours."

This member-driven approach to offering Texas physicians what they want from organized medicine is something that Mr Mickey feels strongly about. His belief that that's the key to success had its origin many years ago, when he was fresh out of the Navy and wondering what to do with his life.

"A friend who was just out of the Army and I used to sit at Louie's Bar and Lounge on 17th and San Jacinto and drink beer and talk about our futures. We decided that what we needed to do was open up a storefront on Congress Avenue. We'd have a table and three chairs and a single light bulb hanging from the ceiling. Nothing else. People walking down Congress Avenue would look in, see the two of us sitting there, and they'd come in and ask, 'What do you do?'

"And we'd respond, "What do you want done?"

That same sense of service comes through today in Mr Mickey's regular reminder to TMA staff members: "The doctors are not *our* members. We are *their* staff." ★

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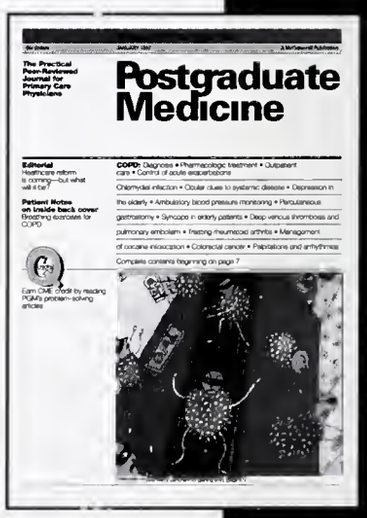

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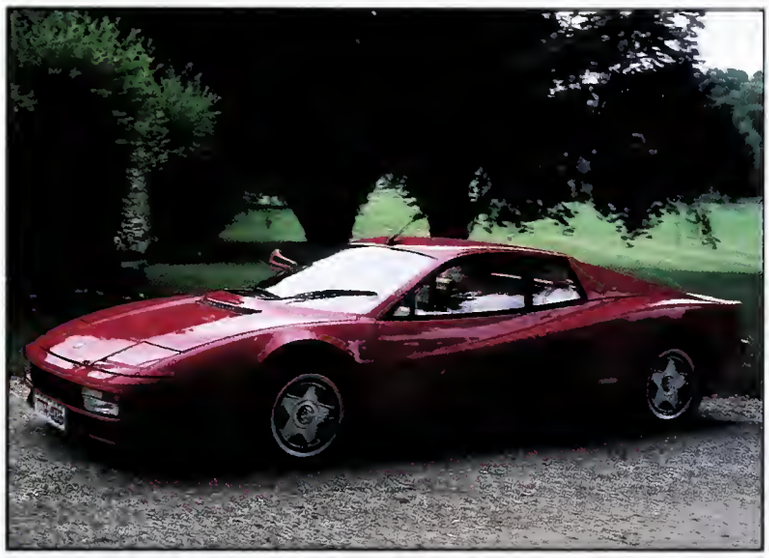

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YCODONE	XX	XX	XX	XX	XX

space indicates that no such activity has been reported. Table adapted from Facts and Comparisons nd Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Med.* 1980 588-96.

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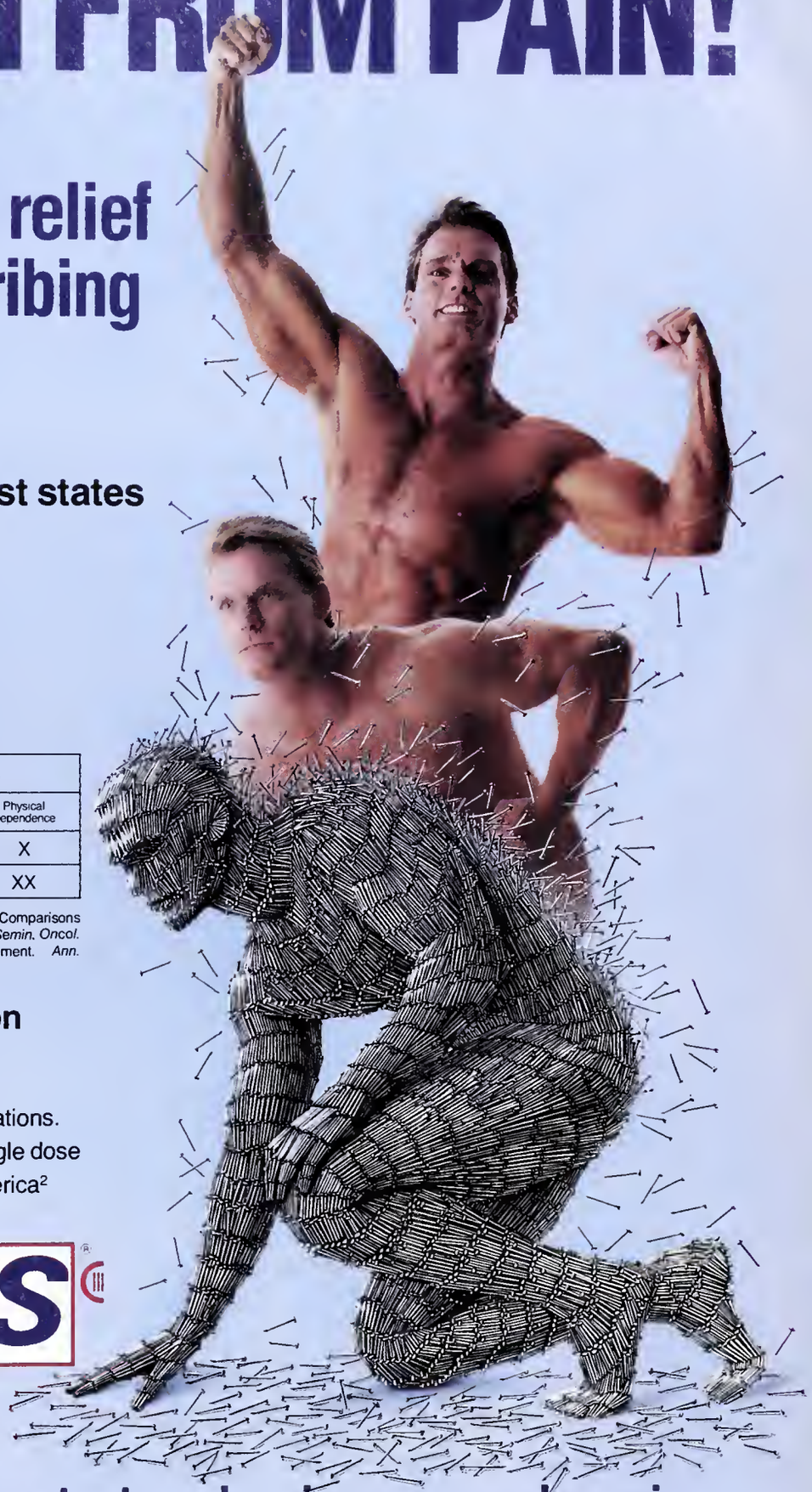

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1. Data on file, Knoll Pharmaceuticals
2. Standard industry new prescription audit

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INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.

WARNINGS:

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

PRECAUTIONS:

Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

Usage in Pregnancy:

Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

Labor and Delivery: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS:

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

Central Nervous System: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

Gastrointestinal System: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

Respiratory Depression: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

DRUG ABUSE AND DEPENDENCE:

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.

OVERDOSAGE:

Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

Hydrocodone Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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—Leo E. Hollister, MD, The University of Texas Medical School, Houston
JAMA, Volume 266, July 17, 1991, p. 424
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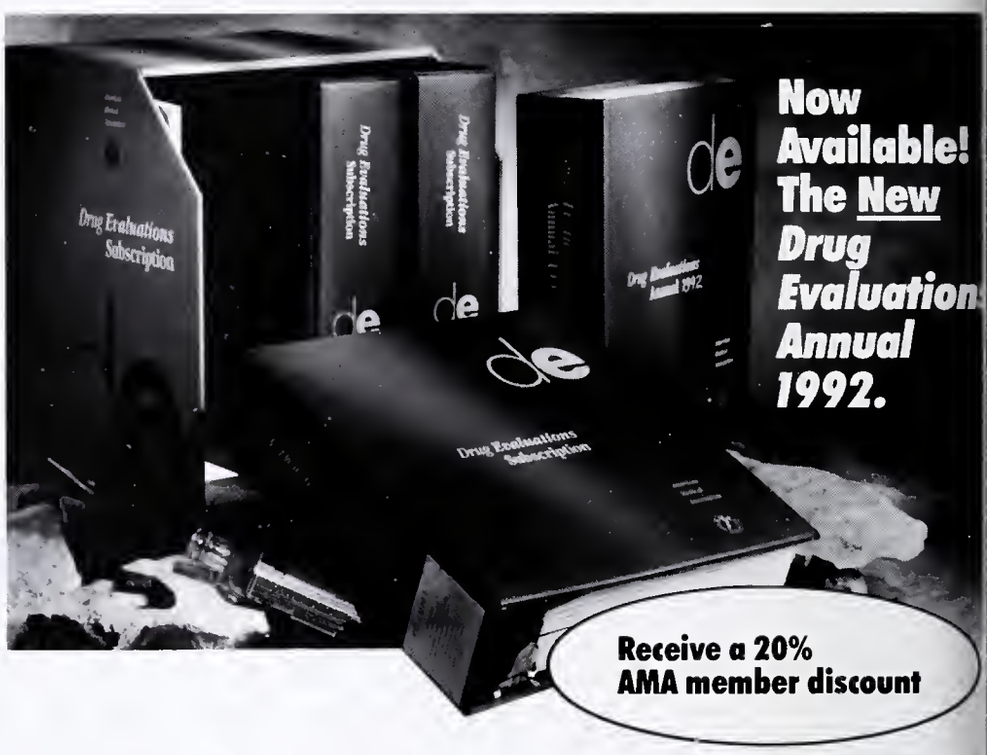

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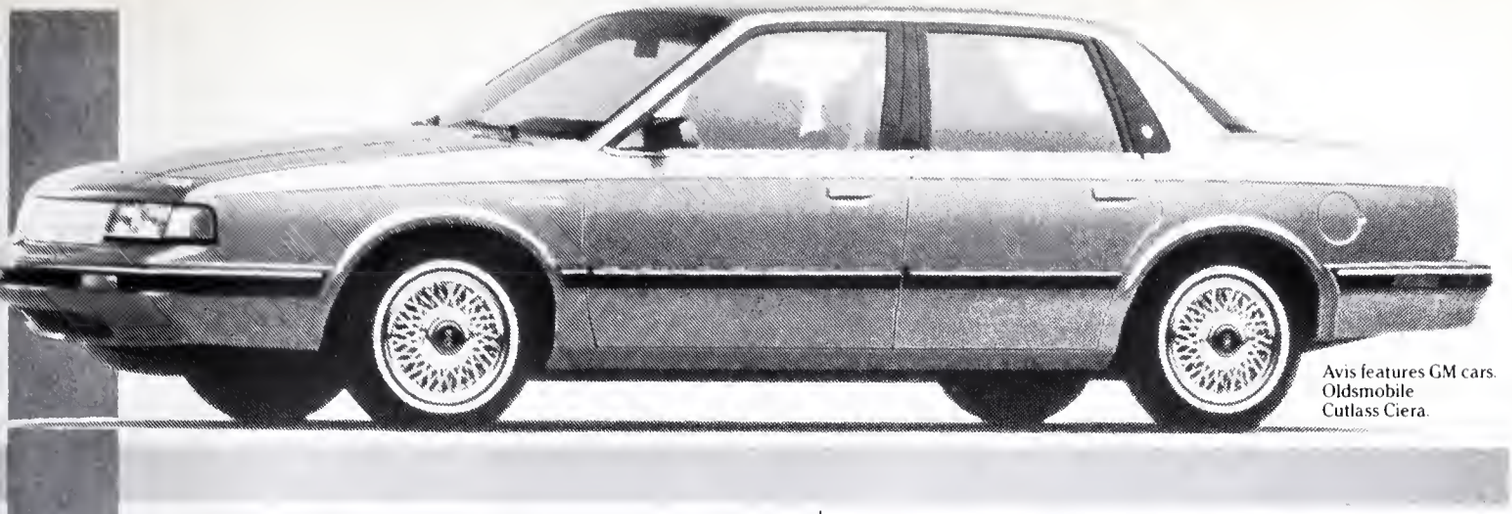

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Law

Preparation for OSHA inspection can calm fears

With OSHA's new regulations establishing a standard on bloodborne pathogens becoming effective at various dates this year, some physicians have voiced concern about the increased possibility of a visit from an OSHA compliance officer. To provide an insight into the OSHA inspection process, Texas Medicine *interviewed a former US Department of Labor attorney, Jane Matheson, JD. Practicing in the area of OSHA laws since 1974, Ms Matheson is now in private practice in Austin, representing employers in OSHA enforcement actions under the Occupational Safety and Health Act of 1970.*

By May 5, all covered physician/employers are required to complete a workplace exposure control plan, according to the new OSHA regulations. This written plan must include:

1. a list that identifies the job classifications at the workplace where all employees have occupational exposure to bloodborne pathogens or other potentially infectious materials;
2. a list of job classifications where some employees have occupational exposures, including a description of the specific tasks and procedures associated with the exposures;
3. a time schedule and description of how the employer will implement the other requirements of the standard; and
4. a procedure for postexposure evaluation and follow-up.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

In addition to the exposure control plan, record-keeping requirements and employee training are required by June 4, and implementation of the remaining provisions, such as providing hepatitis B vaccination, must take place by July 6.

Failure to comply with the regulations can result in fines of up to $70,000 per incident, according to OSHA. And physicians must be aware of the potential for employee-filed complaints, says Ms Matheson, a former deputy assistant secretary for OSHA.

"When a regulation is aimed in the direction of a well-educated group of employees, like those in the medical field, there is a potential for complaints," she says. Following up on those complaints is standard operating procedure at OSHA.

"OSHA inspectors have limited discretion," says Ms Matheson. "They cannot play favorites saying, 'Let's inspect Dr X and not Dr Y.' That's not the way it works. If there is a valid employee complaint and OSHA doesn't follow-up, then OSHA inspection procedures are not being followed and, the next thing you know, someone is called on the carpet. It's not that OSHA has it 'in' for anyone. OSHA is an enforcement agency and the way they fulfill their statutory responsibility is to enforce regulations uniformly rather than unpredictably or arbitrarily. While I have plenty of disagreements with many of OSHA's regulations and interpretations, as well as their application in specific cases, I generally find that OSHA is striving for consistency in enforcement."

To help ease the anxiety some physicians may be experiencing about the new regulations, Ms Matheson answered the following frequently asked questions. As is always the case in situations involvir legal issues, physicians shoul consult their own attorneys o specific areas of concern.

Q: How does OSHA determine which pra tices will be inspected for compliance?

A: There are two types of inspe tions: programmed and nonpr grammed. Programmed inspectior occur when specific establishmen are identified for inspections as th result of a neutral, administrativ plan such as random selection of e tablishments within high hazard ir dustries. Each OSHA area offic should be consulted for further ir formation on how an establishmer in a particular standard industri classification code could appear on programmed inspection list.

It is more likely that a physician office would be inspected as the r sult of a "nonprogrammed" inspe tion. The nonprogrammed inspe tion is normally the result of referral from another enforcemer agency or a complaint being file OSHA will conduct a health inspe tion in response to a valid, form employee complaint in offices wit one or more employees.

Q: What happens if a complaint is fil against a physician/employer?

A: As is the case with inspection there are two types of complain that could be filed against phys cians: formal and nonformal. A fo mal complaint is filed in writin signed by an employee or his or h designated representative, and d scribes an alleged violation th could result in serious physic harm. If the conditions of a form complaint are met, OSHA will co duct an inspection.

A nonformal complaint is one r ceived from a former employee or,

TMA requests delay of OSHA regulations

TEXAS MEDICAL ASSOCIATION PRESIDENT Sam A. Nixon, MD, has requested a delay in the implementation of OSHA's Bloodborne Pathogens Standard. In a letter sent March 5 to the US secretary of la-or, Dr Nixon wrote:

"We are sure that the new regulation on Occupational Exposure to loodborne Pathogens is intended to protect employees from illness and eath, and not to create a legal trap to punish physician employers. There-ore, we respectfully request that the implementation dates of the new rule e delayed so that health care professionals subject to the new rule will have dequate time to comply with the various provisions of the new regulation."

At *Texas Medicine's* press time in early April, no delays had been announced.

ome cases, a third person such as a atient. Generally, for nonformal omplaints, OSHA informs the em-loyer in writing that information bout a possible violation has been eceived and requests the employer investigate the matter and advise SHA of its determination. The em-loyer then has the opportunity to ddress the matter and resolve it ithout an inspection. If serious vio-tions have been alleged and OSHA oes not receive an adequate re-onse to the allegations, OSHA will chedule an inspection. So, physi-ans/employers should never disre-ard inquiries from OSHA.

: What should the physician/employer tell s or her staff about OSHA inspections?

: Each physician's office should have designated person on the staff who as been trained to handle an OSHA ispection, in the event the physician annot be present for the inspection. his person needs to understand the mits of OSHA's inspection authority nd how to react to OSHA's requests r information. For example, before ermitting an inspection to proceed, a etermination should be made as to e basis for the inspection. If the ompliance officer cannot explain at the inspection is being conducted s a programmed inspection or as the esult of a valid, formal complaint, ere may be grounds to challenge SHA's authority to conduct the in-ection without a warrant. If the in-ection resulted from the filing of a rmal complaint, a copy of the com-laint should be provided to the em-loyer at the beginning of the inspec-on. While any denial of inspection without a warrant should be carefully considered and discussed with an attorney, if possible, the compliance officer should be treated courteously, professionally, and in a nonconfrontational manner.

Q: Should the physician/employer be present during the inspection?

A: OSHA anticipates that an employer or his or her representative will want to be present during the inspection and document the progress of the inspection. The physician/employer should greet the OSHA compliance officer in a private office and begin the opening conference in a private setting. If the physician has a busy appointment schedule or patient treatment is in progress, an alternative time for inspection of the facility can be discussed with the compliance officer. Since OSHA asserts the right to interview employees in private, the physician/employer will not be permitted to observe those interviews. Physician/employers and their representatives should be cautioned against signing interview statements or making verbal admissions during inspection. While honest and truthful answers should be given, speculation, guessing, or volunteering information should also be avoided.

Final CLIA-88 regs improved over original

ALTHOUGH THERE WILL BE an increase in costs and supervision as a result of the final rules on the Clinical Laboratory Improvement Act of 1988 (CLIA-88), they show a marked improvement over the original version.

Implementation of the 1,800 page document will take place over a 2- to 5-year period. Most physicians will be able to continue operating their laboratories under the regulations, which were developed to ensure the quality and reliability of medical tests performed by clinical laboratories. The US Department of Health and Human Services' regulations will be funded with registrations and inspection fees. The collection of user (registration) fees from laboratories by HCFA began April 1. Bills are expected to be mailed by May 1 and payment is due 30 days after receipt. Quality standards go into effect on September 1, 1992.

The regulations (stock number 069-001-00042-4) are available by contacting the US Government Printing Office at (202) 783-3238 or FAX (202) 512-2250. Documents are $3.50 per set.

Workers' comp session planned May 14–15

AN EDUCATION CONFERENCE on the new workers' compensation law is scheduled May 14–15 at the Hyatt Regency Hotel in Austin.

Topics at the second Texas Workers' Compensation Education Conference will include fee and treatment guidelines, the billing process, reimbursements, pre-authorization, second opinions on spinal surgery, and medical dispute resolution.

For registration information, contact the Public Information Office of the Texas Workers' Compensation Commission, 4000 South IH-35, Austin, TX 78704-7491, or call (512) 448-7900.

TMA offers booklet on illegal remuneration

MISINFORMATION AND anxiety are two items best left out of a doctor's life. TMA's new booklet on payment for referrals was written to soothe and inform.

The booklet, *Payment for Referrals: A Compilation of Pertinent Laws and Statements on Ethics Relating to Illegal Remuneration*, was developed by the TMA Office of General Counsel. The publication covers Texas and federal law along with ethical issues. Cost of the booklet is $25 for TMA members and $40 for nonmembers. To order, send a check to TMA Office of General Counsel, 401 W 15th St, Austin, TX 78701.

Law protects alcohol, drug treatment records

Hugh M. Barton, JD
TMA Assistant General Counsel

The US government recognizes the importance of the confidentiality of drug and alcohol treatment information. Federal regulations protect records of the identity, diagnosis, prognosis, or treatment of any patient of any alcohol or drug abuse prevention program or activity conducted, regulated, or directly or indirectly assisted by any US agency. Even records of the patient's identity as an alcohol or drug abuse program patient are protected. These records are subject to applicable statutes (42 USC §29ee-3 (drug abuse) and 42 USC §290dd-3(alcohol abuse) and rules (42 CFR §2.11 et seq) that make them confidential. The laws supersede all state law regarding release, even where consent has been obtained.

Q: How do I know if the law applies to medical records I have?
A: If the records bear the following stamp then there is a presumption that the law applies. However, you may conclude after close examination of the records that no protected information is involved.

> "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Q: What does "directly or indirectly assisted" by the federal government mean?
A: Medicare certification, registration under the Controlled Substances Act, or federal tax-exempt status constitutes federal assistance.

Q: When can the records be disclosed?
A: They may be disclosed *only as specifically authorized by the applicable regulations*. The rules apply where the person seeking records already has the information sought, has other means of obtaining it, enjoys official status, has obtained a subpoena, or asserts any other justification or basis for disclosure not expressly authorized in regulations.

Q: When can the records be released without the patient's consent?

"Physicians are looking at a platter full of legal challenges," says Betty Jane Anderson, JD special counsel for the American Medical Association Office of the General Counsel. Ms Anderson discussed legal challenges facing the medical profession at the general session of the TMA Winter Leadership Conference. RBRVS, the Americans with Disabilities Act, OSHA's bloodborne pathogen regulations, and CLIA-88 are all legal areas of concern to doctors, according to Ms Anderson.

A: The disclosure of records withou the patient's express written consen is limited to the purpose of treat ment for medical emergencies, cer tain research activities, and certai audit and evaluation activities.

Q: What if I receive a subpoena for th records? Do I still have to protect them?
A: Yes. A person holding record subject to these federal regulation who receives a subpoena for th records is not permitted to respon to the subpoena unless a court o competent jurisdiction enters a "authorizing order." If an authoriz ing order is entered, the perso holding the records may refuse t make disclosure if there is no sub poena or other compulsory proces outstanding. A person may disclos the records only in response to valid subpoena at that point.

Q: When is an "authorizing order" proper
A: An authorizing order may onl be entered by a court if one of thre situations exists:

1. disclosure is necessary to protec against an existing threat to lif or serious bodily injury; or
2. disclosure is necessary in connec tion with investigation or prose cution of an extremely seriou crime; or
3. disclosure is in connection wit

his form complies with the requirements of 42 Code of Federal Regulations, Section .31(b).

1. I (name of patient) ( ) Request ( ) Authorize:

2. (name or general designation of program that is to make the disclosure)

3. To disclose: (kind and amount of information to be disclosed)

4. To: (name of title of the person or organization to which disclosure is to be made)

5. For: (purpose of the disclosure)

6. Date (on which this consent is signed)

7. Signature of patient

8. Signature of parent or guardian (where required)

9. This consent is subject to revocation at any time except to the extent that the program that is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (specific date, event, or condition).

litigation in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

In connection with the third situa- on listed, it should be noted that his prevents the "offensive use" of nfidentiality; in other words, the atient cannot put his or her condi- on into controversy by filing the wsuit and then block the defense om finding out what that condition . The law does, however, allow for defensive use" of confidentiality. hat means that the patient who is ot relying on evidence of his or her ondition in a suit should be able to rohibit the opposing party from aining access to that information.

: Suppose I receive a request for such ecords accompanied by a general con- ent for release of medical records. Can I elease them under that document?

: No. The federal law specifically provides that a general consent for release of medical records form is not sufficient. A sample consent form, considered legally sufficient by the US government for the patient to authorize release of his or her own federally protected alcohol or drug abuse records, is printed below.

Q: What happens if this law is violated?

A: The federal policy of confidentiality is backed up with stout sanctions: any person who violates any provision of the underlying statutes or regulations may be fined up to $500 for the first offense and up to $5,000 for subsequent offenses.

Q: What should I do if I receive a subpoena for protected records and there is no proper consent form signed by the patient?

A: At the very least, you should make counsel seeking the records aware of the requirements for release under federal law, as it is likely that many lawyers who practice in state court are unfamiliar with these provisions. Where the patient consents to the release it may be as simple as providing the correct authorization form. In other cases it may be necessary to consult and retain counsel to maintain confidentiality of the records as against a subpoena, where the patient has not presented a consent for release form that complies with federal requirements. This may involve taking legal action to block the subpoena and petitioning the court for an authorizing order before releasing the records.

Decision guards pensions from bankruptcy claims

Helene Alt Thompson, JD
TMA Associate Counsel

THE ABILITY OF A BANKRUPT individual's creditors to reach his or her pension has been the focus of much litigation in Texas within the last few years.

As a direct response to a bankruptcy decision that held the benefits of retirement plans are not protected from claims of creditors, the Texas Property Code was amended in September 1987 to exempt from creditors' claims the assets of all retirement plans qualified under federal tax law (1). Subsequently, several courts determined that this Texas law was preempted by provisions of the Employee Retirement Income Security Act (ERISA), the federal law dealing with pensions, and therefore debtors could not exempt retirement plan benefits from the bankruptcy estate under a state exemption scheme (2).

The recent 5th Circuit decision, *In re Dyke*, has resolved the issue of whether a Texas debtor's interest in

a qualified retirement plan is exempt from the claims of his or her creditors in favor of the debtor (3).

Background on bankruptcy law

Upon the commencement of a bankruptcy case, all legal and equitable interests of a debtor in property become part of the bankruptcy estate (4). There are two broad exceptions to this rule: first, trusts that would be considered spendthrift trusts under "applicable nonbankruptcy law" (state law) (5); and second, property that has been selected by the debtor to be exempt as a result of an election between a "federal" or "state" exemption scheme (6).

The federal exemption scheme allows the debtor to exempt property specified in §522(d) of the US Bankruptcy Code while the state exemption scheme allows the debtor to exempt property specified under state law or "other federal law" than §522(d). Most Texas debtors elect the state exemption scheme because Texas law affords a generous homestead exemption (7). Prior to September 1987, however, the election of the state exemption scheme was unfavorable to participants in large retirement plans. At the time, the state exemption scheme did not permit the exemption of a debtor's interest in a retirement plan. A debtor who owned a substantial interest in a retirement plan was relegated to the federal exemption scheme, which authorized the exemption of such retirement plans. Unfortunately, the election of the federal exemption scheme required that the debtor sacrifice the state homestead exemption.

After September 1, 1987, when the Texas legislature enacted §42.0021(2) of the Texas Property Code to exempt ERISA-qualified pension plans under the state exemption scheme, creditors, the obvious foes of §42.0021(a), challenged its validity. The issues that arose from these challenges were basically the three presented to the court in *In re Dyke*:

1. whether the antialienation provision of ERISA, which creates a bar to the assignment or garnishment of qualified plan benefits, was "applicable nonbankruptcy law" (8);
2. whether the antialienation provision of ERISA is "other federal law" under the state exemption scheme; and
3. whether ERISA simply preempted §42.0021(a) (9).

Review of *In re Dyke*

The debtor in *In re Dyke* was a physician who was the sole shareholder of his professional association and the sole trustee of an ERISA-qualified pension plan in the professional association.

The debtor claimed a state exemption under the Texas Property Code of his interest in the pension plan to which the Chapter 7 trustee filed an objection. Both parties subsequently filed motions for summary judgment. The bankruptcy court granted the trustee's motion for summary judgment reasoning that ERISA specifically preempted state law like §42.0021(a) of the Texas Property Code, which related to any employee benefit plan. Dr Dyke appealed and the federal district court reversed the judgment of the bankruptcy court concluding that ERISA did not preempt §42.0021(a) and that the pension plan was ex empt from the bankruptcy estate ur der §42.0021(2). Needless to sa the trustee appealed the decision t the 5th Circuit, which consolidate it with another bankruptcy case ir volving a bankrupt attorney wh was claiming that his defined benef and defined contribution plans wer similarly exempt from his bankrupt cy estate under §42.0021(a).

Retirement plans threatened by bankruptcy proceedings have recently received protection.

"Applicable nonbankruptcy law"

The 5th Circuit rejecte the debtors' argument tha the antialienation provi sion that proscribes th assignment or alienatio of pension plan benefit was "applicable non bankruptcy law" and rei erated that it considere "applicable nonbankrupt cy law" to refer to stat spendthrift trust law.

It defined a spendthri trust as a type of trust cre ated to provide a fund fo the maintenance of beneficiary with only certain portion of the total amour to be distributed at any one time. noted that "self-settled" trusts ar not spendthrift trusts under Texa law (10). In a self-settled trust beneficiary enjoys "access to an control over" a trust even thoug another person or entity nominall created the plan. The court observe that not all ERISA-qualified retire ment plans are spendthrift trusts be cause some are self-settled. Thus self-settled ERISA-qualified retire ment plans are not exempt fror creditors under the "applicable nor bankruptcy law" exception.

.egal articles in Texas Medicine *are intended o help physicians understand the law by roviding legal information on selected top- s. These articles are published with the un- erstanding that TMA is not engaged in pro- iding legal advice. When dealing with pecific legal matters, readers should seek as- stance from their attorneys.*

Other federal law"

'he 5th Circuit also rejected the ar- ument that the antialienation pro- ision of ERISA was "other federal aw" under the state exemption cheme, on the basis that the illus- rative list of laws Congress had ompiled to show what they meant s "other federal law" was highly robative of Congressional intent hat ERISA was not within the roup of "other federal laws."

reemption

inally, the 5th Circuit addressed the ssue of whether the preemption lan- uage in ERISA applies to 42.0021(a). Basically, ERISA will ot preempt a state law unless the tate law relates to an employee enefit plan. Although §42.0021(a) oes not expressly mention ERISA, clearly encompasses ERISA- ualified benefit plans. The reference n the state law to "stock bonus, ension, profit-sharing, or similar lans" is a specific reference to RISA benefit plans, therefore the ourt, absent an applicable preemp- on exception, concluded that RISA preempts §42.0021(a).

However, the court noted that espite the expansive ERISA pre- mption clause, ERISA does not pre- mpt rules and regulations that im- lement and enforce federal law 11). The so-called "saving" clause n ERISA expressly states that the erms of ERISA do not "alter, mend, modify, invalidate, impair, r supersede" other federal laws. 'he court stated that the Bankrupt- y Code relies on state law to assist n the implementation and enforce- ent of its goals.

The principal goal of the ankruptcy Code is to ensure that a ebtor comes out of bankruptcy vith adequate possessions to have a "fresh start." The code adopts a federal exemption scheme that satisfies this goal, but, recognizing that circumstances are different in the various states, the code also "permits the states to set exemption levels appropriate to the locale." If the court were to interpret ERISA to preempt provisions of the state exemption schemes, the states would be unable to set enforceable exemption levels on retirement benefits. This would relegate many debtors to a federal exemption scheme that might be inappropriate to the locale. As a consequence, the court noted that the enforcement scheme contemplated in the Bankruptcy Code would be modified and impaired. If the ERISA preemption clause was enforced against §42.0021(a), the preemption clause would impair the ability of the Bankruptcy Code to ensure — through the Texas state exemption — that Texas debtors could get a "fresh start" after bankruptcy. Accordingly, the court concluded that the savings clause of ERISA saves the Texas state exemption scheme from preemption. ERISA does not preempt §42.0021(a) of the Texas Property Code.

Other exemptions

The decision of the 5th Circuit should be reassuring to physicians who have wondered whether their retirement plans would be safe if they were propelled into bankruptcy by a successful professional liability judgment.

Additional good news for those individuals facing the possibility of huge professional liability judgments that might exceed insurance coverage is that the Texas legislature in the last session amended the Texas Property Code and the Texas Insurance Code. The amendment provides greater exemptions and makes more explicit what exemptions are available and to what extent.

In regard to the Texas Property Code, several beneficial changes were made to the personal property exemptions. However, the most significant was the increase in the maximum dollar limit of allowable personal property exemptions from $30,000 to $60,000 for a family and $15,000 to $30,000 for an individual (12).

In regard to the Texas Insurance Code, the provision regarding exemption of insurance benefits from seizure under process has been amended to make perfectly clear that insurance policy proceeds shall be fully exempt from seizure and not be limited by any cap such as in the Texas Property Code (13).

In conclusion, complete peace of mind may never be attained regarding the security of one's assets from creditors, but the 5th Circuit decision and the recent amendments to Texas law should allow some restful moments (14).

References

1. Tex Prop Code Ann §42.0021 (Vernon Supp 1992).
2. 29 USCA §1001 et seq (West 1985).
3. In re Dyke, 943 F2d 1435 (5th Cir 1991).
4. 11 USCA §541 (West Supp 1992).
5. Id at §541(c)(2).
6. 11 USCA §522 (West Supp 1992).
7. Tex Prop Code Ann §41.0001 and §41.002 (West Supp 1992).
8. 29 USCA §1056(d)(1) (West Supp 1992).
9. 29 USCA §1144(a) (West Supp 1992).
10. In re Brooks, 844 F2d 258 (5th Cir 1988).
11. 29 USCA §1144(d) (West Supp 1992).
12. Tex Prop Code Ann §42.001 (West Supp 1992).
13. Tex Ins Code Ann §21.22 (Vernon Supp 1992).
14. See Alt H: Going bare — do you dare? Tex Med. 1986; 82:55–57. ★

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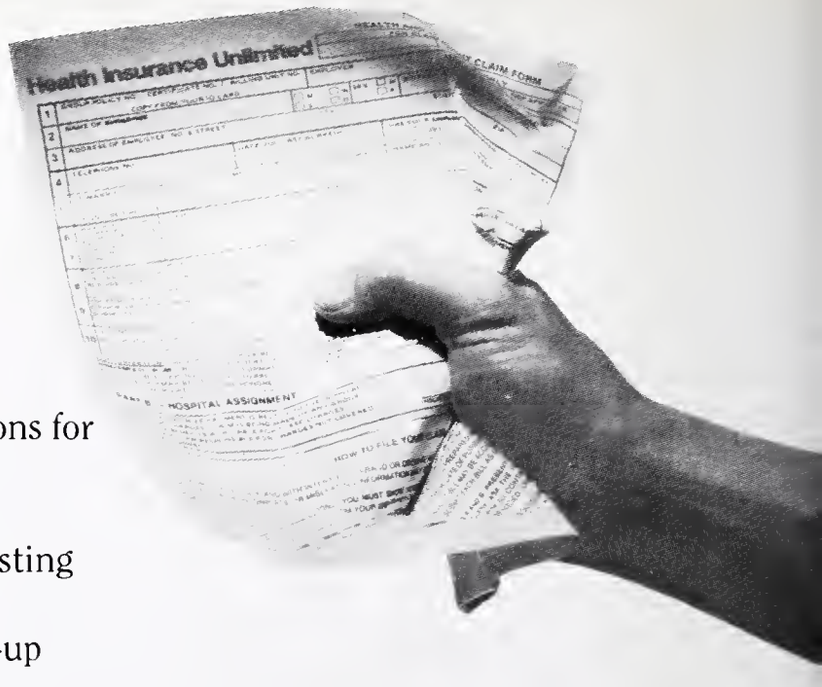

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Science and Education

TMA physician leaders study silicone breast implant issue

RESPONDING TO THE controversial issues surrounding silicone gel breast implants, physician leaders of the Texas Medical Association, meeting in Austin February 29, began formulating policies.

Both the Councils on Communication and Scientific Affairs took up the issue during the 1992 Winter Leadership Conference and made policy recommendations that will be considered by the House of Delegates at its meeting this month in San Antonio.

The Council on Communication reviewed news articles and a resolution to the American Medical Association from the American Society of Plastic and Reconstructive Surgeons regarding the breast implant issue. Silicone implants have been implicated in a variety of diseases in women with them, including autoimmune diseases, lupus, scleroderma, and other rheumatoid conditions, though no clinical evidence of connections has been established.

The federal Food and Drug Administration has called for a voluntary ban on silicone gel breast implants, and in February, an FDA advisory panel recommended severe restrictions on their use. In March, Dow Corning, a primary manufacturer of the implants, announced that it would cease manufacturing the product.

The Council on Communication endorsed several statements related to the physician-patient relationship and the implant issue:

1. Texas physicians have the opportunity to demonstrate to women with silicone gel breast implants TMA's "Physicians Caring for Texans" theme.
2. If a physician does not have the training or expertise to treat a patient's health concerns, that physician should refer the patient to a physician or other health-care professional with appropriate training or expertise.
3. Physicians should work with their patients on financial arrangements that will enable the patients to have their silicone gel breast implants removed, if the patient requests removal.

TWO TMA COUNCILS RECOMMEND ACTION ON THE CONTROVERSIAL SILICONE GEL BREAST IMPLANT ISSUE.

In addition to asking the House of Delegates to approve the physician-patient relationship statements, the Council on Communication also wants the House to urge the Texas Medical Liability Trust (TMLT) to offer risk management education on the silicone gel breast implant issue.

Karin Montero, MD, an Austin plastic surgeon and member of the Council on Communication, said the issue is an urgent one for Texas physicians to deal with.

"These women (with implants and problems) are making a lot of noise and are the ones who are going to increase all of our malpractice liability costs," she said. "The sooner we take care of them, the less they will sue.

"A lot of these women were not being treated, many of them for several years, because they were considered just dumb, complaining wo en. Most of them are not. This is p tentially a major patient relatio disaster," Dr Montero said.

She noted that despite the lack definitive medical evidence abo breast implants, physicians shou still treat their patients.

"There is a potential proble (with implants), thou no one is implying th silicone is the cause. B these people need to l taken care of becau they are sick for whate er reason," she sai adding that physicia need to be more awa of the types of problen many of these patien are having.

"They are our p tients," she said. "W performed a procedu on these women, certai ly never intending to c any harm, but we need be resposible for then just like they need to b responsible for themselves. Let's n keep treating these people poorly."

The TMA Council on Scientif Affairs, in addressing the implant i sue, reviewed policy statements fro the AMA, the Texas Division of th American Cancer Society, the Tex Society of Plastic and Reconstructiv Surgeons, and various news artic on the issue. Council chairman Joh W. Burnside, MD, met with th Committee on Cancer to elicit i recommendations and met wit members of the Council on Commu nications for their input.

The Council on Scientific Affai also heard from a representative TMLT, who said his company ha already received several dozen cas involving breast implants and ha

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

nformation for this column comes from a variety of sources, including aca-'emic institutions, state and federal agencies, and private institutions. To ubmit items of interest, write Texas Medicine, *Science and Education Edi-or, 401 W 15th St, Austin, TX 78701.*

Researchers develop new "gene gun" for immunizations

he University of Texas Southwestern Medical School at Dallas — Re-searchers are using a "gene gun" to shoot DNA-coated "bullets" directly ito the cells of animals, provoking an immune response to the proteins gen-rated by the foreign DNA. Stephen Johnson, MD, associate professor of in-ernal medicine and biochemistry, said this technique may lead to new ways f immunizing individuals against viral infections. "This is so new, we don't now all the possible applications for this technique," he said. "It's a new ngle in approaching the immune system." The gun is hand-held, about the ize of a soft drink can, and derived from a similar device used by molecular iologists to increase the growth potential of crops. In experiments, Dr ohnson and colleagues inoculated mice in their ears with gold pellets coated vith DNA fragments from a human gene. Nearly 88% of the mice produced ntibodies against the protein produced by the human growth gene. The re-earch findings were reported in the March 12 issue of *Nature*.

Study to look at estrogen's effect on women's cardiovascular function

aylor College of Medicine at Houston — Researchers are studying whether estrogen replacement therapy (ERT), already known to trengthen bones, can also make a menopausal woman's heart stronger. Re-earchers suspect that ERT strengthens the heart and improves its ability to ump blood, but have little proof of that assertion. "If this is true, it helps xplain why menopausal women taking estrogen have less cardiovascular isease than those not taking the hormone," said Michael C. Snabes, MD, ie study's lead investigator. "It may also explain why estrogen protects ienopausal women from the heart disease that afflicts their male peers." Menopausal women who are not taking estrogen begin the study with tread-ill and bicycle tests to determine how their hearts function before, during, nd after exercise. The tests will be repeated after 3 months of ERT and af-er 3 months without estrogen. The research project should be completed by arly 1993, Dr Snabes said.

Breast cancer drug suspected to cause genetic liver damage

he University of Texas Medical Branch at Galveston — A drug widely used to treat and prevent breast cancer may inadvertently cause damage genetic cells in the liver, according to researchers here. In studies using ats, UTMB scientists found that tamoxifen citrate (brand name Nolvadex) an accumulate in the liver and cause genetic damage. In findings reported in ie March issue of *Cancer Research*, scientists injected rats with daily doses f tamoxifen citrate in amounts higher than the daily dosage for most wom-n for 1, 3, and 6 days. Results showed that the drug attached to and mutat-d the liver cells' genetic material. Three days after the injections, genetic hanges in the liver cells were found to have increased by sevenfold; at six ays, the increase was 15-fold. "Many women take this drug for prolonged ierapy, and this genetic damage may accumulate," said Joachim G. Leihr, hD, professor of pharmacology and toxicology at UTMB. "This study indi-ates to us that this drug needs further investigation." Tamoxifen citrate was pproved in the 1970s and is commonly used in the treatment and preven-on of estrogen-responsive breast tumors in women.

been advised by plaintiffs' attorneys to expect 500 to 1,000 cases by the end of the year. TMLT representatives suggested that TMA consider issuing a risk management alert to its members regarding the issue.

The Council on Scientific Affairs voted, however, to restrict its recommendation to the scientific issues involved with breast implants. The council recommended that TMA adopt the following statement as policy:

1. The data are insufficient to merit a ban on the silicone gel breast implant.
2. There should be additional clinical trials.
3. An implant registry should be established.
4. The decision to have implant surgery should rest with an informed patient and her physician, and should not be limited to certain categories of restrictions.

The statement from the Council on Scientific Affairs was approved as interim policy by the TMA Board of Trustees in February. It, and the recommendations of the Council on Communications, will be considered by the House of Delegates at Annual Session, May 14–17, in San Antonio.

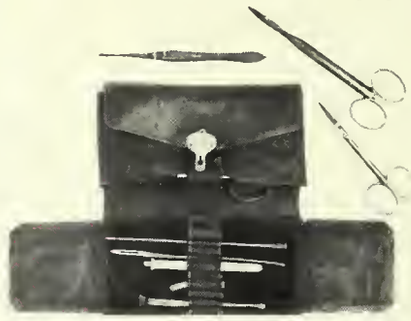
UT, A&M medical schools to launch trauma residency programs

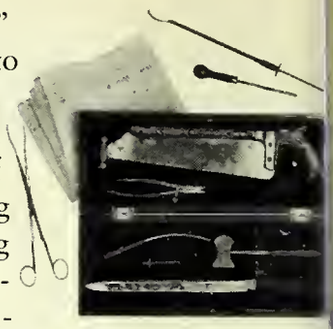
THE LONG AND STORIED rivalry between Texas A&M University and The University of Texas is adding another chapter in 1992. But this time, the winner is trauma care in Texas.

Two new Emergency Medical Residency Programs are being

Military medicine on display at TMA

TMA's "History of Medicine" exhibit is currently featuring "From Sword to Scalpel: The History of Military Medicine in Texas, 1812–1945," on display through June 12 in the first floor lobby of the TMA building in Austin. Among the items on display are a mahogany Civil War surgical case with ebon handled amputation instruments, circa 185 "A Manual of Military Surgery," prepared f use of the Confederate States Army; a pigsk pocket surgical case, circa 1870, owned by George Cupples, MD, first president of the Texas Medical Association in 1853; and a military appointment certificate assigning C.C. Francis, MD, to be the surgeon general of the Texas Regiment Cavalry in 1865, signed by Governor F. R. Lubbock.





launched this summer, one at The University of Texas Medical School (UT-Med) at Houston and another through Texas A&M University (TAMU) Health Science Center in Temple. Both are seen as major steps toward solving the state's and nation's shortage of trauma physicians.

Both programs recently received approval from the Residency Review Committee for Emergency Medicine of the Accreditation Council for Graduate Medical Education.

Texas is ranked third in the number of emergency visits in the US, but only ranks seventh in the number of residency programs. (See "Under Siege: The Embattled Trauma Care System" *Texas Medicine*, January 1992.) Prior to the announcements by UT-Med and Texas A&M, there were three residency trauma programs in the state, and two of those are in military hospitals. The other is at the Texas Tech University Health Sciences Center in El Paso; it trains six residents annually.

E. David Prentice, MD, chairman of TMA's Emergency Medical Services and Trauma Committee, said the new residency programs are sorely needed in the state.

"We've had a profound manpower shortage in Texas for adequate numbers of residency-trained emergency physicians," he said. Because residents tend to practice in localities very near to where they trained, Dr Prentice says the Texas-based programs probably mean "we will have more residency-trained emergency physicians going into practice in Texas, instead of moving off to another state."

Hermann Hospital and LBJ General Hospital in Houston will serve as training institutions for the eight UT residents entering the program. Scott and White Memorial Hospital in Temple will serve the six residents in the Texas A&M program, with rotations at the Olin E. Teague Veterans Hospital in Temple and Darnall Army Hospital at Fort Hood.

Marni J. Bonnin, MD, assistant professor and residency director at UT-Med in Houston, said, "This residency program, the first in the city, will increase the quality of care not only at (local) hospitals, but in the community and the state as our residents graduate to practice, teach, and conduct research."

Carl W. Gossett, MD, residency program director at Scott and White, said the program will be a boost for the TAMU Health Science Center.

"Not many institutions are deemed capable of providing the necessary supervision, faculty support, and educational effort as well as having the facility and appropriate patient mix" for such a program, he said. "It means we'll be able to produce six board-certified emergency physicians every year, many of whom will remain in Texas."

Dr Prentice adds that while the two new programs are a major boost to trauma care in Texas, they are only a beginning.

"It is the feeling of the EMS a Trauma Committee of TMA that should have residency training pr grams in emergency medicine at of the medical schools in Texas," said. "Manpower studies proje that there will be a shortage natio wide in emergency medicine throu the year 2010. This is a great fir step, but it will only help us conter with the tip of the iceberg in t overall manpower shortage."

Both programs will begin in Ju of this year and graduate their fir classes in 1995.

TMA annual CME conference planned June 19–20

On June 19–20, the TM annual conference for conti uing medical educatio (CME) sponsors, "Pathways an Perspectives in CME," will giv physician educators and learners contemporary and provocative pe spective on CME issues, trends, an requirements.

In its Self-Evaluation Report t

e Texas Sunset Commission, the xas State Board of Medical Examers (TSBME) identified mandatory ME as an issue under the 1993 nset review of the TSBME and the xas Medical Practice Act. In Ocber 1991, the US Food and Drug dministration released a proposal r FDA regulation of pharmaceuti- l sponsored activities in scientific educational contexts.

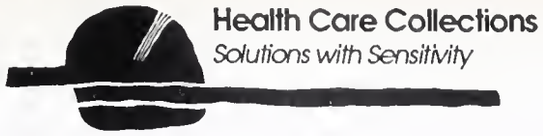
The 1992 CME conference will spond to these primary issues rough discussion panels on "Medl Industry Funding and Conflict Interest in CME" and "Issues and rspectives in Physician Competen- and Mandatory CME".

The controversy of industrynded CME will be explored rough the perspectives of medical dustry, the Accreditation Council CME, the FDA, the Texas medi- l school, and the rural physician.

Mandatory CME panelists will clude projections for the 1993 gislature by Rep David Cain, airman of the Texas Sunset Advisry Commission, and overviews of e Ohio and Illinois experiences th mandatory CME requirements r relicensure.

Other conference activities will clude personal consultation sesns on Physician Oncology Educan Program resources and developnt of accredited CME programs d a variety of workshops on ogram development and meeting creditation guidelines.

For more information and registion material, contact the TMA edical Education Department, 00) 880-1300, ext 1446 or (512) 0-1446. ★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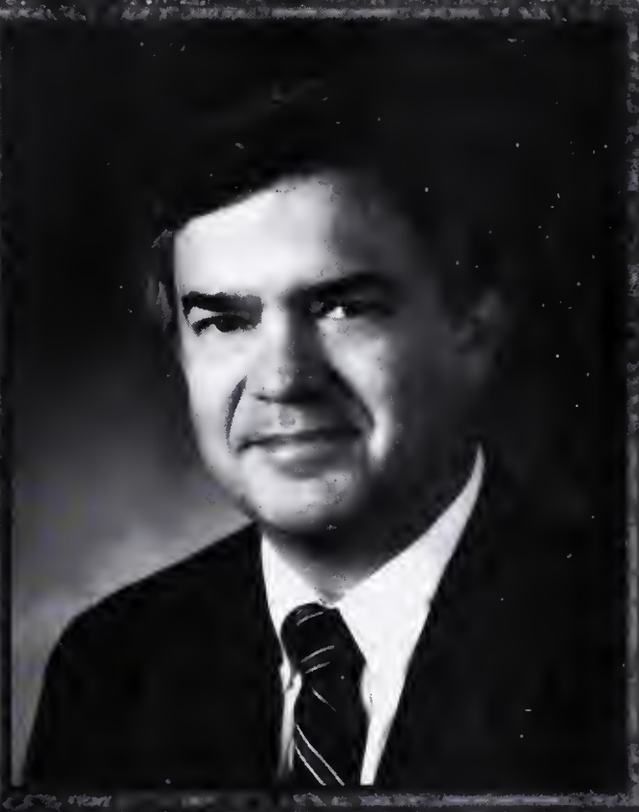

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Legislative Affairs

Legislation filed to correct GPCI errors

LEGISLATION TO CORRECT problems with Medicare's geographic practice cost indices, one of Texas Medical Association's top congressional priorities in 1992, has been filed by US Rep Ralph Hall and more than 30 other congressmen.

HR 4393, the Medicare Geographic Data Accuracy Act of 1992, was filed March 5. The bill would require the Health Care Financing Administration (HCFA) to use "the most recent available data" when calculating the so-called GPCIs. It also would require HCFA to work with each state medical society, or another organization that represents the majority of practicing physicians in a state, in revising the GPCIs. The measure, which would take effect January 1, 1993, calls for no additional spending.

In introducing the bill, Representative Hall, a Rockwall Democrat, described as "ancient" the data upon which current GPCIs for Texas and other states are based.

"The number crunchers in Baltimore took the quick and dirty route . . . in building the scientific database — using that term loosely — for their GPCI," Representative Hall said. "The data is ancient — sometimes a decade old, doesn't measure what it pretends to, and in no way even remotely reflects the actual costs of practicing medicine in places as diverse as New York City and Rockwall, Texas."

Among problems with the GPCIs cited by Representative Hall are basing office rent costs on a 1987 US Department of Housing and Urban Development study of suburban apartment rents; basing employee wages on a 20% sampling of clerical workers and nurses from the 1980 census; and basing physician work on 1980 census data on average hourly earnings of nonphysician professionals, such as teachers and engineers.

He also pointed out that medical liability costs for the Texas GPCIs are based on information from a company that insures only a few hundred of the state's 30,000-plus practicing physicians.

"When the federal government tinkers with Medicare, it is fooling around with one of our most vulnerable constituencies," Representative Hall said. "A seemingly minor statistical adjustment in Washington, barely making a peep or a whimper, goes off like a sonic boom of seismic proportions when it's multiplied across 50 states and millions of elderly people. We should at least be sure that what we launch here is truthful, reliable, and accurate."

Correcting the GPCIs is one of several legislation priorities concerning Medicare set by TMA. A delegation of TMA physician members and staff met with some 20 Texas congressmen in Washington, DC, in January to garner support for the measure.

In addition to Representative Hall, 21 of the original cosponsors of HR 4393 are from Texas, including Reps Mike Andrews (D-Houston); Bill Archer (R-Houston); Joe Barton (R-Ennis); John Bryant (D-Dallas); Albert Bustamante (D-San Antonio); Jim Chapman (D-Sulphur Springs); Ron Coleman (D-El Paso); Tom DeLay (R-Sugar Land); Chet Edwards (D-Waco); Jack Fields (R-Humble); Martin Frost (D-Dallas); Pete Geren (D-Fort Worth); Sam Johnson (R-Plano); Greg Laughlin (D-West Columbia); Jake Pickle (D-Austin); Solomon Ortiz (D-Corp Christi); Bill Sarpalius (D-Amaril Lamar Smith (R-San Antonic Charles Stenholm (D-Stamforc Craig Washington (D-Houston); a Charles Wilson (D-Lufkin).

US Sen Lloyd Bentsen (D-Te also pledged support for GPCI ir provements during his address at t TMA Winter Leadership Conferen in Austin on February 29.

TMA proposes rural health, cost containment measures

FULL FUNDING OF THIRD-YEA clerkships in family practic and medical liability reform are among steps recommended t the Texas Health Policy Task Forc by Texas Medical Association to in prove access to care in rural area and to control health-care costs.

Testifying before a joint meeting the task force's subcommittees on co containment and finance on Marc 12, former TMA President Max Butler, MD, Houston, said fundin third-year clerkships, expanding firs year primary care residency slots, an enhancing loan forgiveness and repay ment programs would help recruit pr mary care physicians for rural and ur derserved areas.

"TMA, through both its polic and its legislative efforts, has strong ly advocated increasing the supply c doctors in manpower shortage areas particularly in primary care in rura and medically underserved areas, Dr Butler told task force members "We created the Family Practic Residency Program nearly 25 year ago and recently helped draft an pass House Bill 18, the Rural Healt Care Recovery Act of 1989, whic

Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs section of* Texas Medicine.

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Max C. Butler, MD, Houston, testifies before the Texas Health Policy Task Force during hearings March 12 in Austin.

quires third-year family practice erkships, rural rotations, expanded se of rural health clinics, demnification programs that en- urage physicians to participate in ate programs of care for the indi- nt, and locum tenens to support olated rural physicians."

Dr Butler's remarks were in direct sponse to questions submitted to MA by the task force.

He said reducing litigation costs, veloping practice parameters, and ressing disease prevention are nong steps needed to control rising alth-care costs.

"Needless to say, the more in- ries and disease you can prevent, e more money you would save in e system," Dr Butler said.

TMA President Sam A. Nixon, ID, Houston, echoed the preven- on message on March 13 when he ddressed the task force's subcom- ittee on essential services.

"More than half our injuries and lnesses are caused by our lifestyles - by things we could prevent along ith the help of physicians," he said.

"We know we may smoke too uch, drink too much, eat too uch, drink and drive too often, and many other things," Dr Nixon said. "And we know it's bad for us. But how many people think of their bad habits in terms of contributing to high health-care costs? The more unhealthy we all are, the more health care and health insurance will cost all of us."

Dr Nixon said TMA is working with the Texas Department of Health, Texas Higher Education Coordinating Board, Texas Education Agency, and other public and private sector groups to find ways to encourage healthier lifestyles and reduce costly, preventable illnesses. In fact, on April 23, TMA hosted a summit meeting that focused on incorporating state and national public health objectives into public and private sector actions.

The Texas Health Policy Task Force was appointed by Gov Ann Richards to present health-care reform recommendations to the Texas Legislature in 1993. TMA representatives were scheduled to appear again before the subcommittee on cost containment on April 3 to discuss liability issues.

The task force also has scheduled a series of hearings across the state. Hearings were planned for April 15 in McAllen and April 22 in Houston. Hearings scheduled in May are: May 5 in El Paso at Misenhimer Auditorium, Texas Tech University Regional Academic Health Center, 4800 Alberta Ave; and May 20 in San Antonio, Room 107, San Antonio Convention Center, 200 E Market St. All hearings will be held from 5 to 9 pm.

TMA encourages physicians to attend the hearings and express their opinions on health-care reform. For additional hearings information, contact the task force at (512) 463-6473.

Bentsen urges "small steps" in health-care reform bill

CONGRESS WILL NOT ENACT sweeping health-care reforms in a "lightning bolt of legislation" during 1992. That's why US Sen Lloyd Bentsen is urging that a series of small steps be taken in order to provide immediate help for some uninsured Americans.

"If we cannot design an immediate, affordable system that works for everyone, let's at least identify some of the most egregious of the problems and see what we can do to take care of them," Senator Bentsen told participants at Texas Medical Association's Winter Leadership Conference. The conference was held in Austin on February 29.

The Texas Democrat also called on physicians and TMA to help find "honest, affordable, equitable answers" to access-to-care problems.

"Our medicine is clearly world class," Senator Bentsen said, "but it is often delivered through an expensive, unwieldy health-care apparatus that leaves more than 30 million Americans in jeopardy. The sad truth is we have the best health-care system in the world for those who can afford it."

US Sen Lloyd Bentsen (D-Tex) emphasizes a point during remarks at the Texas Medical Association Winter Leadership Conference on February 29 in Austin.

Senator Bentsen, who chairs the powerful Senate Finance Committee, is sponsoring S 1872, the Better Access to Affordable Health Care Act. That legislation was incorporated in a tax bill passed in March by the Senate, but eventually vetoed by President Bush. The health-care proposals, however, were dropped from the bill by a House-Senate conference committee prior to the veto.

That means Senator Bentsen likely will seek passage of S 1872 as a separate bill. Since the measure was not subjected to the president's veto, Senator Bentsen may be able to send S 1872 to the House without another Senate vote. The House, however, likely will consider its own health-care reform bill, said AMA lobbyist John Scott.

The senator's proposals, which mirror recommendations developed by the TMA Ad Hoc Committee on Financing and Availability of Health Insurance, include:

- setting federal minimum standards for health insurance sold to companies with fewer than 50 employees;
- prohibiting insurers from excluding one or more individuals from a group because of an existing medical condition;
- guaranteeing that all small employers and their workers will have insurance available to them;
- guaranteeing renewable insurance for small businesses;
- placing limits on the extent to which insurers can vary premiums among small groups, based on their health status or claims history;
- assuring workers that they will not lose coverage because they change jobs;
- making health insurance premiums paid by self-employed individuals 100% tax-deductible;
- encouraging small businesses to band together to bargain for insurance coverage; and
- creating a commission to advise the president and Congress on how to reduce unnecessary costs. Senator Bentsen emphasized the need to reduce paperwork hassles.

Senator Bentsen successfully blocked an amendment by the insu ance industry that would have ti private insurance payments to t Medicare resource-based relati value scale.

Senator Bentsen said his propo als can be accomplished "witho busting the budget." TMA and t American Medical Association ha expressed strong support for t senator's approach.

"You can make major progre with a series of small steps," the se ator said. "In an era of tight bu gets, scarce resources, I think there a good chance we'll see health-ca reform by evolution, not necessaril by spontaneous combustion."

Psychologists challenge admissions rule

TEXAS PSYCHOLOGISTS HAV filed suit challenging a rule th prohibits them from admittin patients to psychiatric hospitals.

The suit, filed February 27 by th Texas Psychological Associatio seeks to overturn a Texas Depar ment of Mental Health and Men Retardation rule that took effe March 1. The rule allows only ps chiatrists to admit patients t psychiatric hospitals. It puts an en to the practice of some private ps chiatric hospitals of allowing admi sions by psychologists.

The suit contends the rule is i valid because it exceeds the depar ment's legal authority. The rule wa enacted in the wake of investigation into patient recruitment methods c some private psychiatric hospital TMA and the Texas Society of Ps chiatric Physicians testified in favo of the MHMR rule. ★

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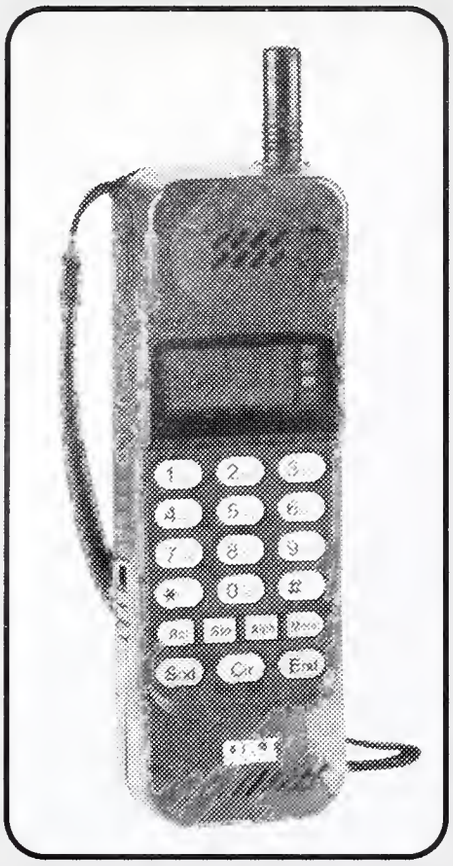

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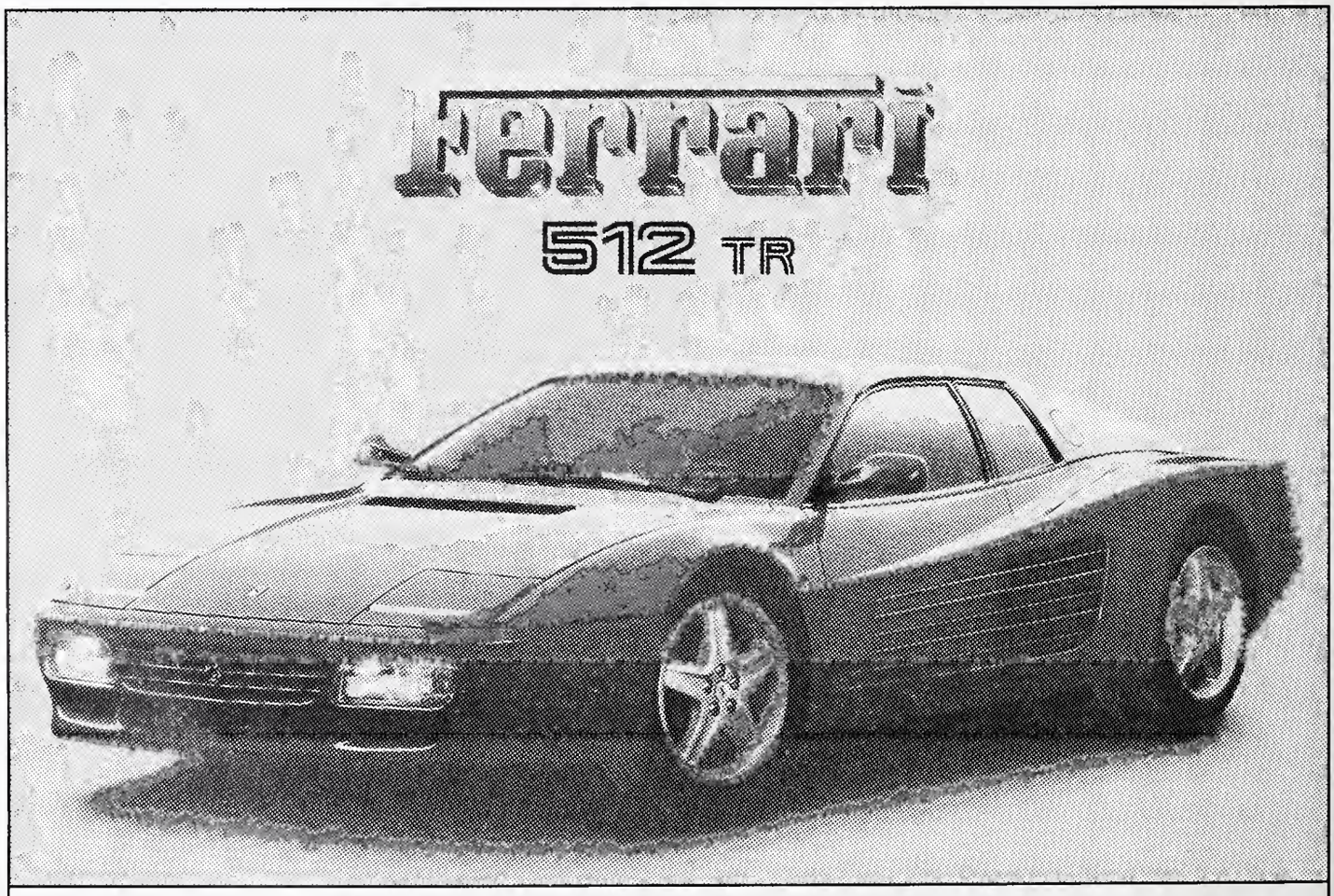

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

Controlling breast cancer in older women: the physician's role

Anne-Claire France, PhD
Mark T. Nanney, MD
Elizabeth W. Riddler, MEd, MS
Armin D. Weinberg, PhD

The number of women older than 65 years is the highest in history and continues to increase. Given that breast cancer is one of the most common cancers among women and that risk increases with age, it is important that older women participate in regular screening. Physician referral is the reason most women receive a screening mammogram. However, as women's ages and risk increase, the frequency of screening declines, potentially putting older women at greater risk. It is advocated that physicians adopt guidelines for breast cancer screening and practice them with their elderly, as well as younger, patients.

About one of every nine women in the United States will develop breast cancer during her lifetime (1). Consequently, this malignancy vies with lung cancer as the most common cancer causing death among women. In 1989 alone, 42,000 women died of breast cancer and 142,000 new cases were diagnosed. Research indicates that the risk of breast cancer increases with age. From 70% to 80% of breast cancers are detected in women older than 50 years (2), and the incidence does not peak until age 85 (Fig 1).

Long-term survival in breast cancer depends upon detection and appropriate therapy at the earliest stages of development when the chances for cure are high. Annual mammography coupled with an annual clinical breast examination is currently the most effective technique available to screen breast cancer at an early and treatable stage (3).

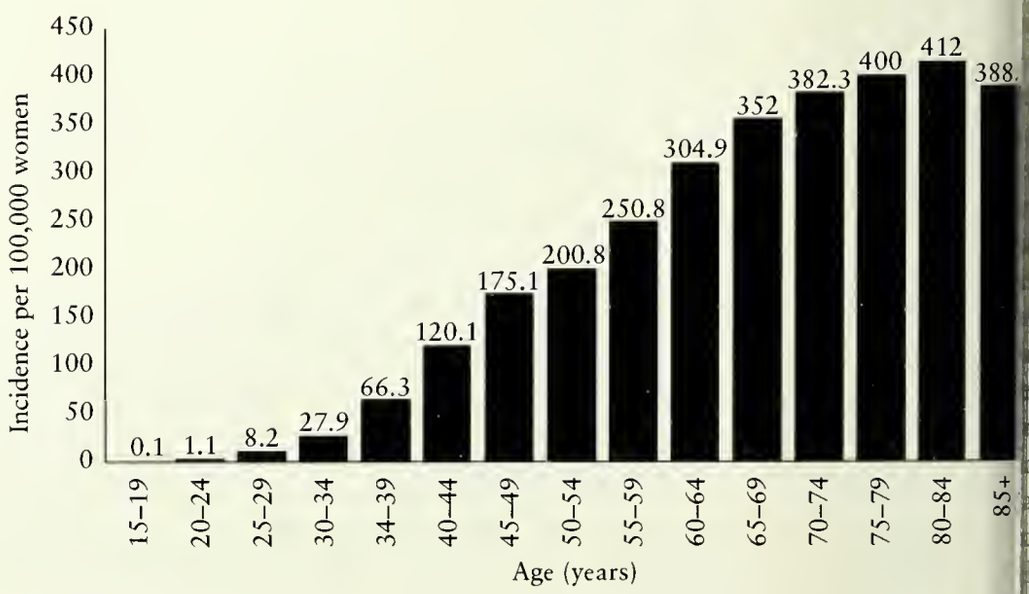
WHY SCREEN?

The benefits of screening have bee well established in the literatur Mortality rates for breast canc have not declined in more than 6 years even though mammograph has been available as a safe scree ing tool since the 1970s (4). R search suggests that the early dete tion provided by adequate screenir could decrease mortality caused b breast cancer in older women by a estimated 30% (5). Given the ease c early detection and, thus, the pote tial cure, we should not wonder th failure to diagnose breast cancer is common foundation for malpractic complaints (6).

EXTENT OF THE PROBLEM

Despite the existence since 1982 c national recommendations for ann al mammograms for women 50 yea and older, most have never had mammogram. Moreover, only 5% c women in this age group are estima ed to have annual mammograms.

Fig 1. Average annual incidence of breast cancer in women by age, 1982 to 1986.*



**Annual Cancer Statistics Review: Including Cancer Trends 1950 to 1986.* Washington, DC: N tional Cancer Institute; 1989. Public Health Service publication NIH 89-2789.

Dr France, Memorial Geriatric Evaluation and Resource Center, Memorial Healthcare System, 7737 Southwest Freeway, Suite 425, Houston, TX 77074; Dr Nanney, Department of Family Practice and Community Medicine, The University of Texas Medical School at Houston; Ms Riddler, The Methodist Hospital, Houston; and Dr Weinberg, Center for Cancer Control Research, Baylor College of Medicine and The Methodist Hospital, Houston. The authors are members of the Wellness is Ageless Committee of the American Cancer Society, Houston. Send reprint requests to Dr France.

A recent study of 33 states con-
cted by the Centers for Disease
ntrol indicated that nearly 80%
women aged 50 years or older
ited a physician for routine pre-
itive care in the past 12 months;
wever, only 29% of these women
d a screening mammogram during
t time. Estimates of these per-
tages varied across states. Texas
orted 29% (7). Further, data
m the 1987 Texas Behavioral
k Factor Survey indicate that
y 25% of Texas women aged 50
rs and older participate in regu-
mammography screening (8).

Despite indication of low fre-
ency of screening mammography,
percentage of older women hav-
screening mammograms appears
be increasing. This increase may
due to a number of factors in-
ding public and private educa-
nal efforts and media attention
en to well-known women with
ast cancer.

RRIERS TO SCREENING

1984, a survey of primary care
sicians revealed that physicians fre-
ntly reported they were not follow-
the American Cancer Society
delines. They believed that
mmography was too costly, not
essary without symptoms, not
essary every year, or involved too
ch exposure to radiation. A similar
dy conducted in 1989 showed some
ouraging trends. Most physicians
veyed by the American Cancer So-
y disagreed that annual testing af-
age 50 was too frequent. More
n 80% are ordering more screening
mmograms. Reasons given for the
eased use of mammography are as
ows: mammography succeeds in
ecting breast cancer, it is recom-
nded by the American Cancer Society and in the literature, it is increasingly reliable, and patient awareness and demand for it is rising (9).

One of the most prevalent barriers to screening for breast cancer is that physicians overestimate patient resistance to receiving a mammogram. They continue to believe that mammograms are too expensive. Cost was the single most important factor that discouraged physicians in 1989 from using screening mammograms more often with asymptomatic patients (9). The evidence is conflicting regarding the importance of cost in a woman's decision to have a mammogram. Nationwide surveys of women ranging in age from 50 to 74 years sponsored by the National Cancer Institute in 1987 indicated that, contrary to physicians' concerns, cost was not a significant factor (4). However, women participating in many other studies have reported that the cost of a mammogram does play a critical role in their decision making. In fact, a recent American Cancer Society project showed that cost was the greatest priority for patients regardless of income and was even a concern for half of those patients with incomes greater than $100,000 (10,11).

Other reasons patients give for not having mammograms include lack of physician referral, lack of perceived need, and fear of exposure to radiation. Research indicates that physicians play a critical role in mammogram utilization. Physician recommendation is the reason most women not only have their first screening mammogram but also adhere regularly to subsequent screenings (12,13).

Many women simply do not know about the importance of screening mammography. Women who take advantage of low-cost mammography tend to be better educated and aware of the importance of mammography even in the absence of symptoms.

Both patients and physicians have reported that they fear required radiation may cause cancer rather than detect it. Radiation levels currently in use are lower than 1 rad (14). The risk of radiogenic breast cancer in women who have a baseline screening at age 35 and annual xeromammograms after age 40 is estimated to be one tenth of 1%. Researchers project that mammography would detect 93,000 breast cancers over the same period. Such a risk-benefit ratio would appear to be acceptable (15). Other reported fears are related to psychological denial, fear of mastectomy, and discomfort or pain associated with the procedure itself (16,17).

In the past, many different professional organizations have independently developed guidelines for the early detection of breast cancer. Physicians thus have had the task of deciding which of the many available guidelines were the most appropriate for their practice policies. Many of the recommendations differ. The age at which to begin screening via clinical breast examination (CBE) and mammography, the frequency of follow-up, the effectiveness of breast self-examination (BSE), and the notion of a "baseline" mammogram are subjects where recommendations differ among professional organizations. Such variation in guidelines may contribute to confusion and skepticism among physicians, thereby leading to failure to comply with any guideline.

In 1989, a total of 11 organizations including the National Cancer Institute, American Cancer Society, American Academy of Family Physicians, and American College of Radiology came to a consensus and endorsed the following guidelines (18):

- It is recommended that the screening process begin by age 40 and consist of annual clinical examination with screening mammography performed at 1- to 2-year intervals.
- Beginning at age 50, both clinical examination and mammography should be performed annually.
- The recommendations apply only to women without signs or symptoms of breast cancer; the frequency and type of examination will vary for the individual with symptoms and should be determined by the responsible physician.

The American College of Obstetricians and Gynecologists (ACOG) raises the question of optimal frequency of screening mammography. Given the cost, the Committee on Gynecologic Practice of ACOG advocates prudent utilization. However, until the optimal interval for screening is determined, ACOG recommends following the guidelines of the American Cancer Society and the National Cancer Institute (19). The United States Preventive Services Task Force recommends screening mammography every 1 to 2 years, beginning at 50 years of age and concluding at approximately 75 years unless pathology is detected (20).

Of interest is that BSE is not included in any of the above guidelines. Considerable controversy exists regarding the efficacy of BSE because there have been no successful prospective studies of women who have practiced self-examination over a long time. Therefore, most professional organizations neither endorse nor discourage BSE per se. Nevertheless, significant numbers of women continue to find lumps; 84% of malignancies are found by women practicing BSE.

CONCLUSIONS

The gap between practice and guidelines is greatest in the elderly; risk increases while frequency of screening declines. Existing guidelines for screening for breast cancer offer physicians recommendations that range from stringent to flexible in practice. Although the percentage of physicians who observe guidelines has increased over the last 5 years, the percentage of physicians' practice policies that are outside the most flexible guidelines is significant. Therefore, many women are potentially at increased risk. The data supporting use of clinical breast examination and mammography are sufficiently robust to question any justification for not following some screening guidelines for breast cancer.

We support the guidelines of the 1989 consensus. We urge physicians to advocate these screening guidelines for breast cancer and to practice them with their elderly as well as their younger patients.

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Breast cancer in elderly women

Fazlur Rahman, MD

MMENTARY

Breast cancer, the most common cancer in the United States, constitutes a major national health problem. In 1991, an estimated 175,000 new cases were diagnosed while 44,500 patients died of this disease (1). It is also the most frequent malignancy in Texas where, out of a total of 59,000 new cancer cases last year, 8,800 were breast cancer in female patients; this disease killed 2,200 Texans during the year. The incidence of breast cancer is rising nationwide, particularly among older women (2).

The elderly bear the brunt of the burden of breast cancer — more than 43% newly diagnosed patients are 65 years or older (3). The number of older people is increasing rapidly, and soon almost every family will have an aged member to care for. Currently, 30 million — 12% of all US citizens — are older than 65 years. By the year 2030, persons older than 65 will number 65 million and account for 21% of the US population (4). The growing number of older people and the higher incidence of breast cancer will compound the difficulties of controlling this disease.

To combat the epidemic, early diagnosis is important. Mammography is at present our best tool for early diagnosis. But to be objective, we must qualify the term "early" diagnosis as a biological misnomer. A 1-cm "early" cancer has 10^9 (1 billion) cells and has already passed through 30 doublings. Cancers that have accomplished 40 doublings are lethal for most patients. One model of growth for breast cancer estimates that the average preclinical duration of the malignancy is about 8 years (5). The idea that breast cancer is a systemic disease from the start has been known at least since 1896 (5). Clearly, mammography is not a panacea, and we need more than mammography to forestall the plague (6).

Problems accompany mammography, both of underdiagnosis and of overdiagnosis. False-negative results are yielded in 10% to 15% of these tests. (7). Overinterpretation of benign or nonexistent abnormalities (7% in one study) lead to the potential for unnecessary biopsies (8). The quality of the technique and of the reading has been questioned under certain circumstances (6,8). Radiologists are held increasingly accountable for their interpretations of screening mammograms (9).

As France and her colleagues point out, clinicians are also baffled by the conflicting recommendations for breast cancer screening. The American Cancer Society, the National Cancer Institute, the American College of Obstetricians and Gynecologists, the American College of Radiology, the American College of Physicians, the US Preventive Service Task Force, and the American Academy of Family Physicians, among others, have all made recommendations at one time or another (10). While some organizations have come to a consensus, others still differ. Two of the most influential entities — the American College of Physicians and the American Cancer Society — still endorse diverse guidelines (11). The time has come for these organizations to set aside their differences and to issue clear, concise guidelines for practicing physicians.

Although the merits of breast self-examination are being disputed, the procedure should still be encouraged for the following reasons. Approximately 90% of all palpable breast cancers are probably detected by the patients themselves. For many poor

Rahman, West Texas Medical Associates, 5 Knickerbocker Rd, San Angelo, TX 904.

and disadvantaged women — young or old — self-examination may be their only means of detection (7). And finally, self-examination has no financial cost.

A few words about the treatment of breast cancer in the elderly are pertinent. Chronological age has little bearing on the selection of cancer treatment. The patients' quality of life and functional status are the primary determinants of therapy. Even patients with breast cancer who are 75 years or older have benefited from chemotherapy for metastatic disease (12). And hormones such as tamoxifen are easily tolerated by elderly patients and are valuable for adjuvant as well as systemic treatment (7).

Thus, we have therapies available that can be used to enhance the quality of life for the elderly patient with breast cancer.

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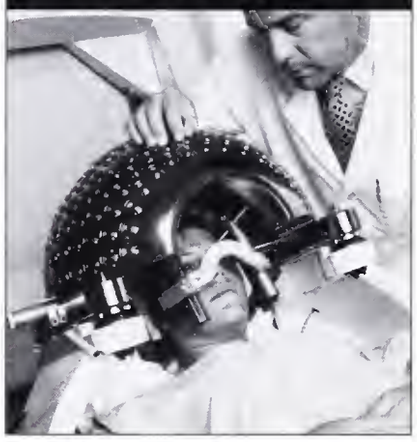

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Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request.

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Houston suburb — Highly regarded medical staff seeks another solo practice internist to join them. Supported by a 135-bed full-service, well equipped hospital in Baytown, only 20 miles from Houston. The medical staff has a full array of specialists who make a conscious effort to support each other professionally. Affordable housing, excellent schools and no state income taxes. Generous first year compensation/benefit package includes a $90,000 net guarantee, one year free rent, plus $5,000/month for office expenses. Contact Bob Haley at 1-800-486-3020 or send/fax CV to Lowderman & Haney, Inc., 3939 Roswell Road, NE, Suite 100, Marietta, Georgia 30062 FAX: 404 977-6549.

Internist needed in rapidly growing area, office space available of retired physician. Clinic with two family practice, one internist, two OB/GYN. For details contact Waxahachie Medical Center, 201 Ferris, Waxahachie, Texas 75165.

Houston — Join prestigious two physician group in medical center. Salary plus incentive bonus leading to partnership. For details contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800 933-0911.

Locum Tenens

OB/GYN

Expanding 15-physician multi-specialty group has excellent opportunity for an OB/GYN physician in friendly West Texas community of 25,000. Adjacent to a 153-bed modern hospital. Excellent guaranteed salary with no first year expenses in addition to benefits. Moving allowances also available. Direct inquiries or send CV to Gail Knous, Malone and Hogan Clinic, 1501 W. 11th Place, Big Spring, Texas 79720. 915 267-6361.

SOUTH TEXAS

Obstetrician/Gynecologist, board eligible or certified, to join an incorporated practice of 2 board certified Ob/Gyns. Subtropical Gulf Coast area with excellent water sports, hunting and fishing all year round. Gender no barrier. Excellent salary, full range of benefits. Send CV to Ad Box 785/Advertising, 401 West 15th, Austin, TX 78701.

Houston suburb — Highly regarded OB/GYN seeks an associate to join thriving practice. Supported by a full-service, well-equipped hospital in Baytown, only 20 miles from Houston. This is an absolutely perfect opportunity in a group practice with a net guarantee ($145,000 to $190,000, dependent upon experience) and excellent benefits package, leading to early partnership for a BC/BE physician. Call Bob Haley at 1-800-486-3020 or send/fax C.V. to Lowderman & Haney, Inc., 3939 Roswell Road, NE, Suite 100, Marietta Georgia 30062. FAX: 404 977-6549.

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Orthopaedic Surgery

Abilene — An extremely busy boarded Orthopedic Surgeon, practicing in new medical complex next to our hospital in high-growth section of Abilene, is seeking an associate. Attractive guarantee. Send CV to Gordon Crawford, Professional Relations, Humana Inc., Dept. TX5-2L, PO Box 1438, Louisville, KY 40201-1438, or call Toll Free 1-800-626-1590, ext. 193.

Orthopedic Surgeon BC/BE — Outstanding opportunity for a General ORS to join a well established, respected practice in a beautiful mid-sized Texas coastal city; a great place to raise a family. You will office and practice in a state-of-the-art 150 bed facility now under construction. Excellent financial arrangements and benefits with an unlimited and rewarding potential. Contact: Healthcare Dynamics, 4615 N. Braeswood Ste 2070, Houston, Texas 77096 or call Jerry Nisenson 1-800-944-4047.

Pediatric

Abilene — Pediatrician needed to establish in a new medical complex next to our hospital. Excellent financial/marketing assistance. Send CV to Gordon Crawford, Professional Relations, Humana Inc., Dept. TX5-2L, PO Box 1438, Lousiville, KY 40201-1438, or call Toll Free 1-800-1590, ext. 192.

Psychiatric

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A UHS career enables individuals to serve their community while enhancing their professional goals, as well as the freedom to transfer among UHS managed facilities without loss of seniority or accrued benefits. Other benefits include a competitive financial package. Qualified candidates located within the Austin area may call (512) 259-0774. If out-of-town, please call 1-800-366-8656, fax or send resume to: Meridell Achievement Center, Attn: Curriculum VITAE, P.O. Box 87, Liberty Hill, TX 78642; fax (512) 259-5107. An Equal Opportunity Employer.

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Expanding 15-Physician multi-specialty group has excellent opportunity for a radiologist in friendly West Texas community of 25,000. Adjacent to a 153-bed modern hospital. Excellent guaranteed salary with no first year expenses in addition to benefits. Moving allowance also available. Direct inquiries or send CV to Gail Knous, Malone & Hogan Clinic, 1501 W 11th Place, Big Spring, TX 79720, 915 267-6361.

Diagnostic Radiologist with CT, MR, Interventional, US, Nuclear Medicine skills to join group of 7 Board Certified Radiologists. Two hospitals, private offices, service to nearby communities. Centrally located to San Antonio, Austin, Houston, Corpus Christi. Good family environment. Contact James Neumann, M.D., Box 3610, Victoria, TX 77903. 512 578-0317.

Radiologist, Tyler Texas. The University of Texas He Center at Tyler, Texas, invites applications for a cli faculty position in the Department of Radiology. S teaching, but publishing or research not required. A gressive four-person department practices general ology (including interventional, MRI, and SPECT) and forms approximately 27,000 exams per year. I equipment, flexible work hours, very light call, no w end schedule. Year-round tennis, golf, and boating available in addition to excellent schools. Compet first-year salary and an unsurpassed benefits pack are offered. Send CV to J.R. Shepherd, MD, Universi Texas Health Center at Tyler, PO Box 2003, Tyler 75710, or call at 903 877-7100. The University of Te Health Center at Tyler is an affirmative action, equal portunity employer. Minorities are encouraged to app

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214/443-9955 (DALLAS)
214/443-9960 (FAX)

Radiologist — Part-time position, approximately 6 ho per weekday. No nights or calls on weekends. Send to: PPM, 1075, Kingwood Dr, Ste 204B, Kingwo Texas 77339. 713 358-8113.

Urology

Houston suburb — Superb opportunity for urologists siring a private practice supported by a 135-bed full-s vice hospital. Baytown is only 20 minutes from Houst and near the Gulf of Mexico. It has excellent schoo affordable housing, and no state income taxes. I tremely attractive compensation package, including r guarantee ($145,000 to $195,000, dependent up experience), one year free rent, and $5,000/month office expenses. Contact Bob Haley at 1-800-486-30 or send/fax C.V. to Lowderman & Haney, Inc., 39 Roswell Road, NE, Suite 100, Marietta, Georgia 300 FAX: 404 977-6549.

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/icki Truitt.

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PRACTICE

TEXAS
well-established family practice group and ped, financially sound JCAHO accredited are looking for two BC FPs to handle patient volume. Located in Central Texas, es from a major lake and 18-hole golf ountry club, this opportunity offers an g life style to the physician who wishes to full range of family medicine. Competitive package available to qualified physician. Barry Strittmatter.

EXAS
e hour of San Antonio - South Texas ty seeks BE/BC family practitioner for rea of 20,000. OB is available, but not Hunting, fishing (fresh and salt water) and eational activities abound. Forty-two bed vill offer generous incentive package to andidate. Contact: Barry Strittmatter.

RTH
amily practice residency program in the eeks division director to coordinate faculty ent, (clinical) research and grant activities. encompasses teaching, patient care and tive responsibilities. Prefer physician with ice experience; board certification required. sistant professorship appointment to major chool; good income and benefits; little to no the team and enjoy your profession! icki Truitt.

FORT WORTH
Family physician needed to deliver basic primary care in "fast track" unit of busy ER. The regular hours of this position will allow you to enjoy a nice lifestyle in a city with tremendous amenities. Salaried position. Call us for details. Contact: Vicki Truitt.

HIGH PLAINS
Young well-trained BC FP seeks compatible FP associate for rapidly expanding family practice; includes OB. Community of 5,000 with service area of approximately 15,000. Excellent quality of life; good schools. Abundant outdoor recreational opportunities available, including nearby lake. City of 200,000 within 45 minutes. Generous financial package will be offered to qualified candidates. Contact: Jim Truitt.

NORTH CENTRAL TEXAS
Great location! Tremendous need for primary care! Call sharing available, or bring a friend/colleague and practice together in this north central Texas community of approximately 24,000 (serving referral area of 195,000). Regional medical center with modern facilities and equipment. Incentive package. Area renown for recreational facilities. One hour from Dallas/Fort Worth metropolitan area.
Contact: Vicki Truitt.

INTERNAL MEDICINE

SOUTH TEXAS
Thirty minutes from Padre Island. IM group, specializing in critical care, seeks third compatible associate. Great climate and lifestyle. Recreational opportunities abound. Excellent income potential. Contact: Barry Strittmatter.

FORT WORTH
Tired of the hassles of private practice? Board certified internist needed for full time clinical faculty position. Manage medicine service at major teaching hospital; medical school clinical faculty appointment available. Subspecialty interests helpful but not required. Nice salary and benefits; very limited call responsibility. Contact: Vicki Truitt.

OBSTETRICS/GYNECOLOGY

NORTHEAST TEXAS
Regional medical center serving 200,000 seeks BE/BC OB/GYN for private practice (to share call with three other OB/GYNs). Progressive, family-oriented community with strong, diversified economy; excellent schools. Many social and recreational opportunities. Comprehensive incentive package to qualified physician. Contact: Vicki Truitt.

Please call for additional listings.

ONCOLOGY

FORT WORTH
Full time medical oncology position at teaching hospital in D/FW Metroplex; clinical teaching appointment to UT medical school. Manage oncology division, develop full time oncology teaching service; work with house staff. Utilize modern facilities; infusion lab. Regular hours and limited call. Attractive income and benefits. Contact: Tim Truitt

PEDIATRICS

NORTH CENTRAL TEXAS
Recently trained, BC female pediatrician seeks compatible associate for private practice. Four-way shared call. Competitive income and benefits. Attractive area with easy access to Dallas/Fort Worth. Contact: Vicki Truitt.

NORTHEAST TEXAS
Dynamic group of American trained, BC pediatricians seek fourth associate for group practice in attractive community of 27,000 (referral area of 200,000). Progressive, family-oriented community with strong, diversified economy; excellent schools. Social and recreational opportunities abound. Modern hospital with Level II nursery and designated pediatric care unit. Shared call; excellent income and benefits; early partnership. Contact: Vicki Truitt.

SURGERY

NORTHEAST TEXAS
Regional medical center serving 200,000+ seeks vascular surgeon for private practice opportunity of 27,000. Progressive, family-oriented community with strong, diversified economy; excellent schools. Many social and recreational opportunities. More than 100 doctors in town. Shared call; competitive incentive package to qualified physician. Contact: Jim Truitt.

NORTH CENTRAL TEXAS
Regional medical center in community of approximately 24,000 (referral area of approximately 2000,000) seeks general surgeon. Shared call; modern facilities. Located in one of Texas' leading recreational areas. Easy access to D/FW Metroplex. Competitive incentive package to qualified surgeon. Contact: Vicki Truitt.

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Colorado Springs, Colorado

Progressive, growth oriented physician-owned freestanding urgent/occupational medical network located at the base of Pikes Peak in Colorful Colorado Springs, CO. is seeking full and part-time BC/BE MD's to come enjoy the good life. Four days per week--**NO NIGHTS/HOSPITAL.** Excellent salary plus bonus. Outstanding benefits package, including: Malpractice insurance, CME benefits, vacation, and health benefits plan. Please send CV to Robert S. Hamilton, MD, 4520 Northpark Dr., Colorado Springs, CO 80918, or call 719/590-1458.

Position Available — Seeking BC/BE Family Practice, General Internist, Endocrinologist, OB/GYN to join established multi-specialty clinic. Excellent benefits and guarantee. Send CV to Leroy W. Kitch, Administrator, Skinner Clinic, 124 Dallas St., San Antonio, TX 78205.

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Call 1-800-284-4560
Houston: 785-3722
or send CV: 11140 Westheimer
Suite 144
Houston, TX 77042
Reuben Bronstein & Associates

Ambulatory Surgery Center in Dallas Texas seeking BC/BE internist or family practitioner to perform pre-op physical and to monitor pre-op patients. No weekends, call or evenings required. Salary 80K plus benefits. Benefit package includes medical, dental, and malpractice insurance. Please send CV and photo to Dr. Whitman, 12308 Shiremont Dr., Dallas, Texas 75230.

Austin TX — Expanding and progressive urgent care clinic group welcomes inquiries of interest from Physicians with family practice, pediatrics, or occupational health backgrounds. Competitive compensation schedule, benefits, and incentive bonus program. Full-time and part-time positions currently available. Call Wayne Campbell at 512 473-2222, or write Austin Minor Emergency Clinic, PO Box 6479, Austin, TX 78762-6479.

Correctional Healthcare

Full time primary care Physicians & Psychiatrists, statewide adult correctional facility locations, new **salary increases effective 3/1/92**/benefits/Physician student repayment program. Inquires: TDJC, Box 99, Personnel Annex, Huntsville, TX 77342-0099 or contact Glynda Baker, **(409) 291-4020**.

Texas, Over 160 Opportunities in FP, IM and IM sub-specialties. Metro, suburban and rural location. Guarantees range from $90-$150,000. For details contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082. 1-800-933-0911.

Physician needed for Bariatric clinic (WT. MGMT.) In Houston suburb. Patient monitoring & counseling. High growth practice. Outstanding professional and financial rewards. Position to be filled soon. For consideration send resume/CV to: Physician, PO Box 566, Humble, TX. 77347 or FAX info 713 540-1913.

Physicians for Nationwide Travel. Health research organization seeks physicians for National Health & Nutrition Examination Survey sponsored by the U.S. Public Heath Service. Individual will be a part of a large medical team conducting health examinations in govt. mobile exam centers traveling to 88 areas of the U.S. through 1993. Must be licensed in one state. One year minimum commitment and FULL-TIME CONTINUOUS TRAVEL REQUIRED. Competitive salary, paid malpractice, per diem, car, four weeks paid vacation per year, holidays and health, life, dental, disability insurance offered. Call Beverly Geline, 800 937-8281 ext 8248. WESTAT, Inc., Rockville, MD EOE/MF/V/H

FOR SALE OR LEASE

Medical Equipment

Medical Equipment — All types of equipment from Autoclaves to X-Rays. Medexchange, Inc., 3021 Carmel St., Dallas, TX 75204. 214 824-5040. FAX: 214 823-9428.

Office Space

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Family Practice lab closed 12/31/91. Very good technical machines and supplies and equipment for sale. Prices very reasonable. Call Leslie 512 349-1405.

Practices

Selling Your Practice? We offer practice evaluations & brokerage, physician recruiting, and partnership buy-in services. We can help you make the right decisions. For a free brochure, call or write: Practice Dynamics, Dept T, 11222 Richmond, Ste 125, Houston, TX 77082. 713 531-0911.

Available For Sale in Colorado Springs, CO — General Surgery hospital-based practice. Sale includes Penrose Hospital office lease, equipment, patient records, managed care contacts and referral base. Contact: 25 East Jackson, Suite 305, Colorado Springs, Colorado 80907. 719 636-0075. FAX Number: 719 636-0070.

For Sale — Large well established solo family practice midway between Dallas/Fort Worth, TX. Excellent hospital facilities nearby. MD will stay and introduce new physician, plans retirement. Reply to Ad Box 798, 401 West 15th St, Austin, TX 78701.

El Paso — Firmly established Family Practice available. Excellent patient base. Grossing $350,000+, with over 80% private insurance and self pay. Well located modern office is fully computerized. Courteous and efficient staff will stay, if desired. Reply to: Ad Box 800, 401 West 15th, Austin, Texas 78701.

Fourteen year established Family Practice — Near north San Antonio hospital. Available immediately or delayed transfer possible. Located in a new medical building containing a variety of specialties. CAT scans and MRI's available within the building. Send credentials and inquiries to: Practice, 212 Sagecrest, San Antonio, TX 78232.

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CME / Continuing Education Directory

Courses

JUNE

Cardiology

June 3–6, 1992
Advanced Echocardiography and Doppler Ultrasound. San Diego. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

June 11–13, 1992
Recent Advances in Cardiovascular Therapeutics. Boston. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Computer Applications

June 17, 1992
Basics of Searching MEDLINE. Austin. Contact Texas Medical Association Library, 401 W 15th St, Austin, TX (800) 880-1300 or (512) 370-1547

Emergency Medicine

June 10–11, 1992
Emergency Care Update. Arlington. Contact CareFlite Fort Worth, 1301 Pennsylvania Ave, Fort Worth, TX 76104 (817) 882-4010 or (800) 772-5840

Endoscopy

June 19–20, 1992
Colonoscopy and Colonoscopic Polypectomy. New Orleans. Contact Conferences Ltd, 211 E 18th St, New York, NY 10003 (212) 673-8927

June 24–25, 1992
Colonoscopy and Colonoscopic Polypectomy. Portland, Me. Contact Conferences Ltd, 211 E 18th St, New York, NY 10003 (212) 673-8927

June 26–27, 1992
Colonoscopy and Colonoscopic Polypectomy. Seattle. Contact Conferences Ltd, 211 E 18th St, New York, NY 10003 (212) 673-8927

Neurology

June 19–20, 1992
Epilepsy: The Next Generation. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Obstetrics and Gynecology

June 14–17, 1992
Ob-Gyn Seminar. South Padre Island. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

June 18–19, 1992
Diagnosis & Management of Lower Genital Tract Neoplasia. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Oncology

June 19–20, 1992
Tracheoesophageal Puncture: Voice Restoration After Total Laryngectomy. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Ophthalmology

June 11–13, 1992
Cornea & Contact Lens Seminar. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Orthopedic Surgery

June 5–7, 1992
Orthopaedic Surgery Review. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Otolaryngology

June 11–13, 1992
Otolaryngology Update. Galveston. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Pediatrics

June 15–19, 1992
Acute Care Pediatrics Review & Update. Hilton Head, SC. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

June 18–20, 1992
Pediatric Review & Update. Galveston. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Plastic Surgery

June 4–7, 1992
Advances in Aesthetic & Reconstruc Breast Surgery. St Louis. Contact Wash ton University School of Medicine, O of CME, 660 S Euclid Ave, St Louis, 63110-1093 (800) 325-9862

Risk Management

June 11, 1992
From Deposition to Courtroom Wo shop. Houston. Contact Texas Medical sociation, 401 W 15th St, Austin, 78701 (800) 880-1300 or (512) 370-14

Urology

June 26–28, 1992
Frontiers in Endourology: Laparosc Nephrectomy & Beyond. St Louis. Cor Washington University School of Medic Office of CME, 660 S Euclid Ave, St L MO 63110-1093 (800) 325-9862

JULY

General Medicine

July 2–4, 1992
Highlights in Women's Health Care. S Fe, NM. Contact Scott & White Mem Hosp, Office of CME, 2401 S 31st Temple, TX 76508 (817) 774-4083

July 17–19, 1992
Caring for the Aging Population: Kn edge & Skills for the Primary Care Ph cian. San Francisco. Contact Amer Geriatrics Society, 770 Lexington Ave 300, New York, NY 10021 (212) 308-1

Obstetrics and Gynecology

July 11–13, 1992
Issues in Care: Ob-Gyn. South Padr land. Contact Scott & White Mem Hosp, Office of CME, 2401 S 31st Temple, TX 76508 (817) 774-4083

July 27–29, 1992
Ob-Gyn Summer Seminar. Lubbock. tact Office of CME, Texas Tech Unive Health Sciences Center, Lubbock, 79430 (806) 743-2929

Ophthalmology

July 24–25, 1992
PHACO 1992. Houston. Contact Baylor lege of Medicine, Office of CME, One B Plaza, Houston, TX 77030 (713) 798-49

JGUST

rgy

; 6–8, 1992
nical Allergy for the Practicing Physi-
n. St Louis. Contact Washington Uni-
sity School of Medicine, Office of CME,
) S Euclid Ave, St Louis, MO 63110-
3 (800) 325-9862

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ting Organized: Personal File Manage-
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01 (800) 880-1300 or (512) 370-1547

nily Medicine

; 6–9, 1992
nily Medicine Update. Houston. Con-
Baylor College of Medicine, Office of
E, One Baylor Plaza, Houston, TX
30 (713) 798-4941

nology

, 9–15, 1992
Needle Biopsy Course. Mauna Lani,
vaii. Contact University of California
an Francisco, Extended Programs in
lical Education, Rm LS-105, San Fran-
, CA 94143-0742 (415) 476-4251

Management

15, 1992
nd Rounds in Medical Malpractice.
h Padre Island. Contact Medical Risk
nagement, Inc, 2500 City West Blvd, Ste
, Houston, TX 77042 (713) 789-6518

27, 1992
m Deposition to Courtroom Work-
. Houston. Contact Texas Medical As-
ation, 401 West 15th St, Austin, TX
01 (800) 880-1300 or (512) 370-1411

PTEMBER

natology

11–12, 1992
nd Care. Houston. Contact Baylor Col-
of Medicine, Office of CME, One Baylor
a, Houston, TX 77030 (713) 798-4941

rnal Medicine

8–13, 1992
nsive Review of Internal Medicine.
Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Ophthalmology

Sept 10–13, 1992
Uveitis & Retinal Frontiers. Carmel, Calif. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

Sept 18–19, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Psychiatry

Sept 24–27, 1992
Multiplicity of Approaches to Treatment of Multiple Personality Disorder. Austin. Contact Don Young, Shoal Creek Hospital, 3501 Mills Ave, Austin, TX 78731 (512) 452-0361

Risk Management

Sept 19, 1992
From Deposition to Courtroom. Austin. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411

Sept 19–20, 1992
Grand Rounds in Medical Malpractice. El Paso. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Sept 24, 1992
Grand Rounds in Medical Malpractice. Lubbock. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

TMA Risk Management Seminars

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May–Nov, 1992

From Deposition to Courtroom
May 21, San Antonio
June 11, Houston
Aug 27, Houston
Sept 19, Austin (during TMA Fall Leadership Conference)
Oct 22, Dallas
Nov 19, San Antonio

Calendar of Meetings

• Denotes Texas meeting

May

May 14–17, 1992, San Antonio
• **Texas Medical Association Annual Session**
Contact TMA, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1450

May 16–17, 1992, San Antonio
• *Texas Society of Anesthesiologists Interim Meeting*
Contact TSA, 401 W 15th St, Ste 990, Austin, TX 78701 (512) 370-1659

June

June 18–20, 1992, Austin
• *Texas Medical Association 1992 CME Conference (for Planners and Sponsors of CME)*
Contact TMA, 401 W 15th St, Austin, TX 78701 (800) 880-1300, ext 1446 or (512) 370-1446

September

Sept 11–13, 1992, El Paso
• *Texas Society of Anesthesiologists Annual Meeting*
Contact TSA, 401 W 15th St, Ste 990, Austin, TX 78701 (512) 370-1659

Sept 19, 1992, Austin
• **Texas Medical Association Fall Leadership Conference**
Contact Jon Hornaday, 401 W 15th St, Austin 78701 (800) 880-1300 or (512) 370-1345

Sept 27–30, 1992, Houston
• *Texas Technology Transfer Association*
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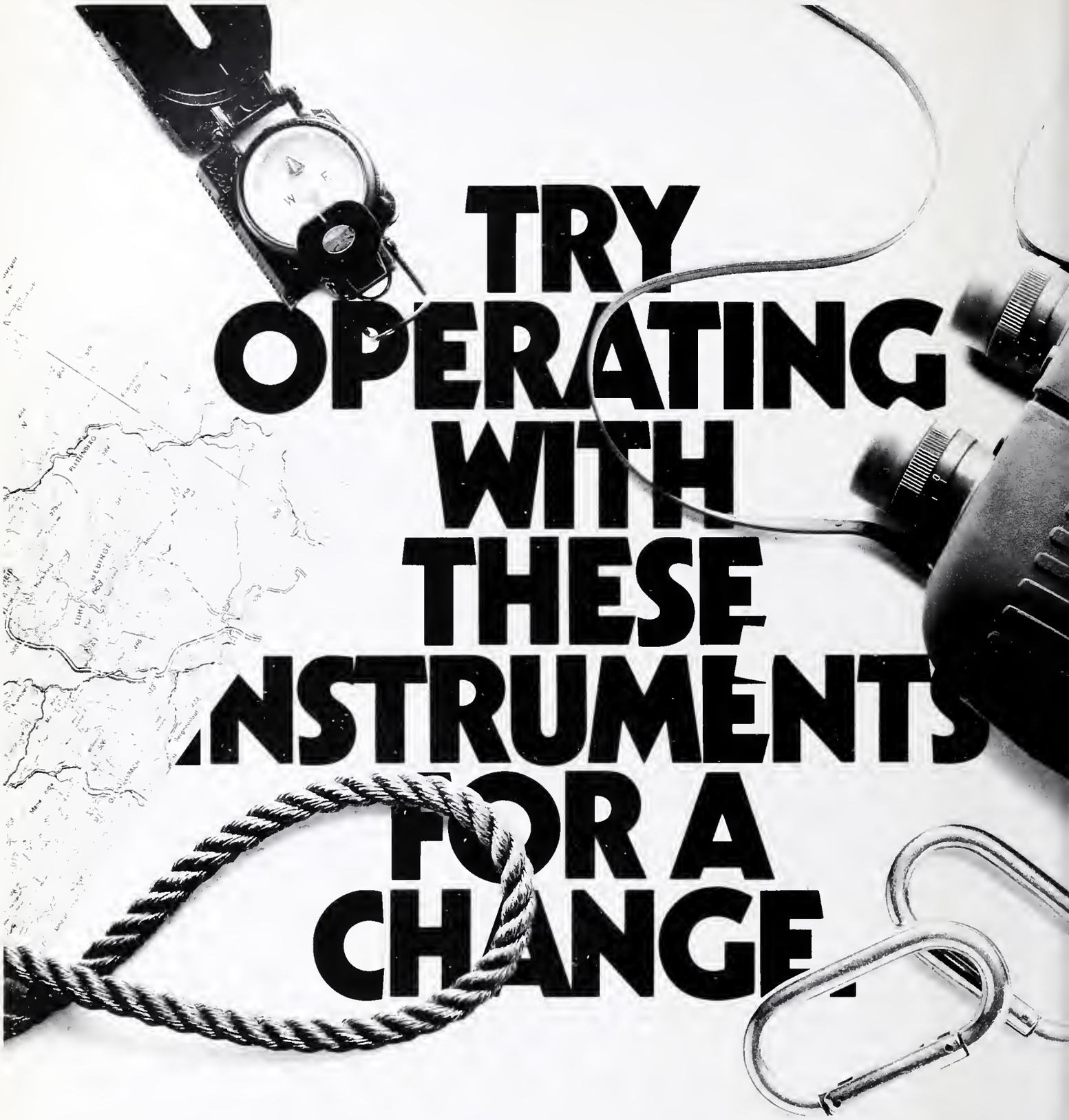

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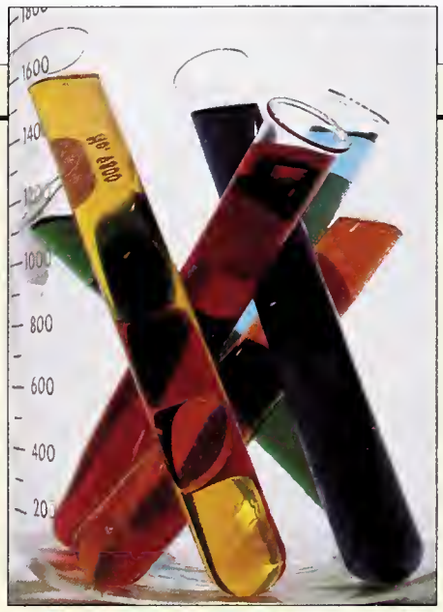

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"Basic research is the lifeline of practical advances in medicine."

— Arthur Kornberg, MD

Big money for big ideas: Medical research in Texas

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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
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3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Current Medical Specialty(ies)

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List surgical procedures routinely performed

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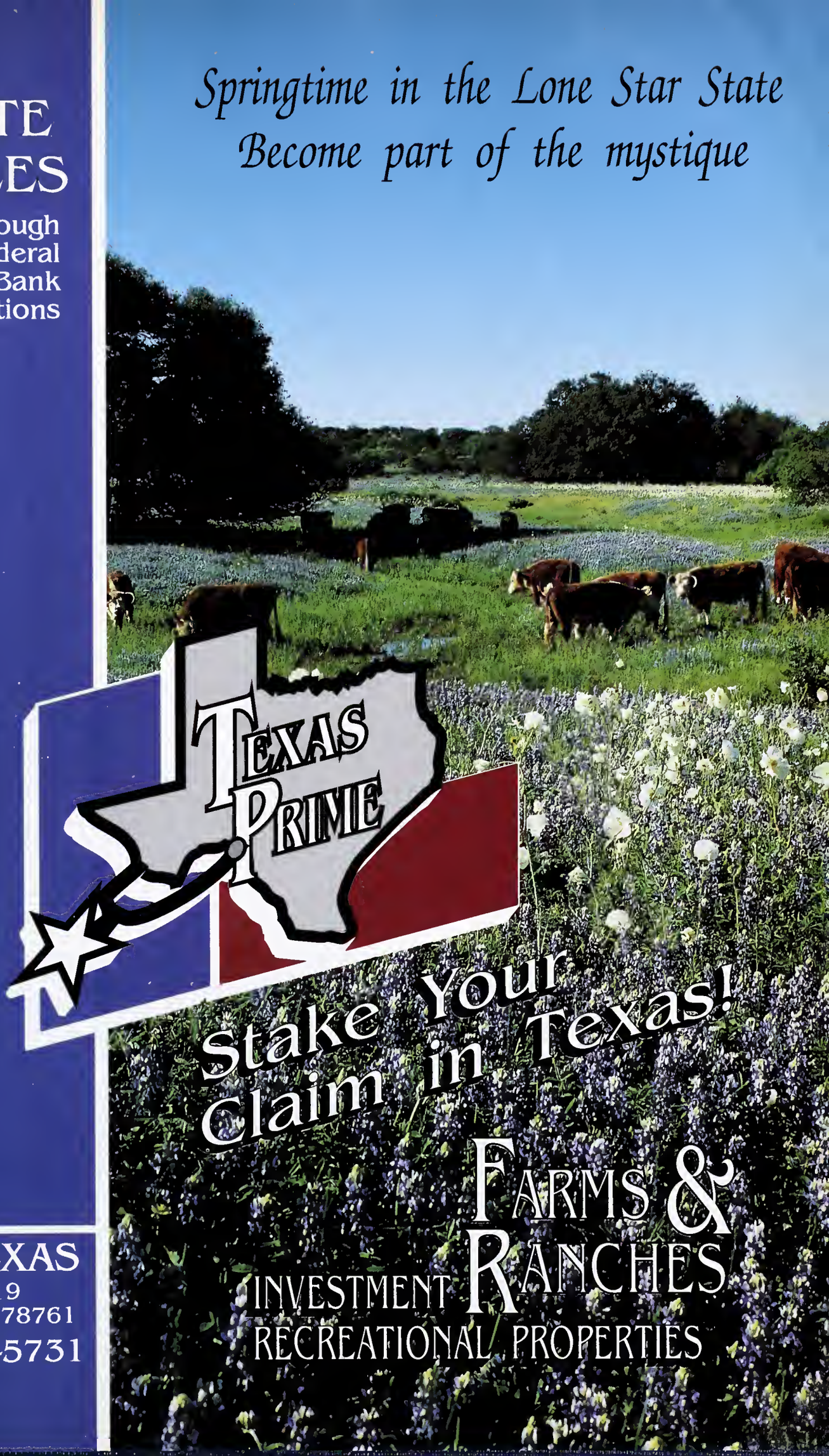

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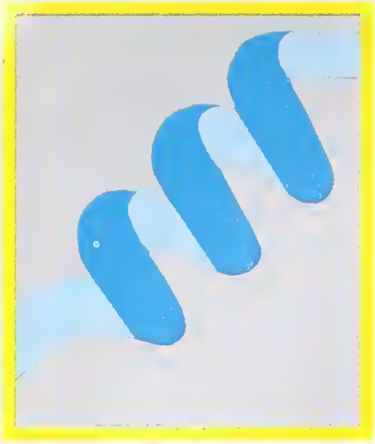

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Letters

Physician defends rural health clinics

I READ WITH INTEREST SOME of the comments about physicians opposing the Rural Health Clinic Program (*Texas Medicine*, January 1992, pp 60–62, and April 1992, p 9).

I have a rural health clinic that has been operating successfully for a year and a half. This clinic has enabled me to continue to see Medicare and Medicaid patients. It is totally private and not subsidized by the local hospital, county, state, or federal government, and it has no government employees. We are operating essentially the same as I did for the 30 years before I established the rural health clinic. We treat private pay patients as well as Medicare and Medicaid patients, with private pay patients paying their own charges and the rural health clinic receiving payment from Medicare and Medicaid. Our situation is not any more a form of "socialized medicine" than any other that accepts payments from the government for treating Medicare and Medicaid patients.

I understand the resentment that might develop in a situation where a local rural health clinic is operated by a hospital or a government agency when it is in competition with private physicians, but I would suggest that private physicians look into this program further. Establishing a rural health clinic in their private practice may enable them to continue to survive in a rural area and to continue to give the medical services that are needed for their Medicare and Medicaid patients.

Sherman A. Hope, MD
901 Tahoka Rd
Brownfield, TX 79316-3899

"If the government would just leave us alone . . ."

I APPLAUD AND COMMEND my colleague Larry W. James, MD, for his letter regarding charity care for the uninsured in our nation ("Providing charity care may help prevent national health insurance," *Texas Medicine*, April 1992, pp 9–10). I think his idea is absolutely correct, and I would much rather give totally free care to those who need it than have the government figure out an onerous way to do it for me. If the government would just leave us alone with our private patients and leave medicine "the way it used to be" as Dr James suggests, then we could take care of our private patients in a manner that reestablishes the rapport, trust, and satisfaction that must exist between physician and patient.

The national organization of Physicians Who Care strongly advocates that we all donate one day per month to charity care. I would urge Dr James and other Texas physicians to join Physicians Who Care (1-800-545-9305) and to have their patients join Patients Who Care.

If the government wants to help us administer free care, then let them establish a means test to find out who really is uninsured and how best to get them into our offices so we can help them. If a strict means test could be performed by the government and somehow the free care could be equitably rationed, then I think all of us would be more than glad to donate one working day per month to charity care.

Then, perhaps, the government and the PPOs would get off our backs and let us deliver the proper "American" form of care that we best know how to deliver. That is what the American public is used to. American health care is the best in the world, and Americans don't want bureaucratic amateurs stepping between doctor and patient.

Michael H. Coverman, MD
12 Oaks Medical Center
11623 Angus Rd, Suite 25
Austin, TX 78759

No easy solution for homicide rate

In response to Dr Doherty's letter concerning gun control (*Texas Medicine*, March 1992, pp 9–10), David F. Zane, et al, cite an article in the *New England Journal of Medicine* as "important work" demonstrating the beneficial effect of restrictive licensure on gun-related deaths in Washington, DC (1).

James J. Baker, executive director of the Institute of Legislative Action, states that "The handgun freeze has been an abject failure, with Washington recording the three highest homicide rates in the history of American big cities." The institute's research coordinator Paul Blackman, PhD, states: "The current *NEJM* article plays a shell game by averaging the homicides from 1968 to 1976 in order to raise the pre-law average so the post-law average looks lower. It is phony." He further states that by using raw data instead of rates per 100,000, the article enhances the illusion of effectiveness as the District of Columbia population fell about 20% during the period studied. Also, by stopping their inquiry with 1987, the authors "handily avoided the problem of Washington's recent record setting homicide years."

Too many people are looking for

an easy solution (gun control) to a problem that has its roots, I believe, in the destruction of the basic unit of our civilization, the family, by a permissive society. The abolition of guns will not solve the dilemma.

William Jones, MD
4800 NE Stallings Dr, #108
Nacogdoches, TX 75961

Reference

1. Loftin C, McDowall D, Wiersema B, Cottey T. Effects of restrictive licensing of handguns on homicide and suicide in the District of Columbia. *N Engl J Med.* 1991;325:1615–1620.

Could a national health system really be worse?

I AM READY FOR NATIONAL health insurance.

I cannot remember any patient for whom I completed an incomplete abortion in the middle of the night and who had a full stomach who was not either unemployed and uninsured, or address unknown, or a welfare recipient. In taking care of these very high-risk individuals, I am not only wide open for malpractice suits, but I have minimal chance for any financial remuneration.

I want to do what I do best and that is taking care of patients, but I also want to know that I *will be paid for my efforts.*

I want to know that if I work twice as hard or twice as long, my compensation will be twice as much.

I want to be assured that if I need a consultation, my consultant also will receive remuneration.

Among the disadvantages predicted in a nationalized health system is the patient's loss of the right to choose his or her own physician. But with more and more people joining private HMOs that cater to exclusive groups of physicians while excluding other physicians, many patients have already lost this right.

A second reported disadvantage is an increase in the waiting period for elective surgery. I don't necessarily see this as a disadvantage. In this era of "instant gratification," some patients are not even willing to carry a diagnosis of nonsymptomatic gallbladder disease for any length of time. Too often they want the problem dealt with immediately, using the latest technology, despite the fact that the disease was discovered only because the x-ray cassette was placed too low during a routine chest x-ray.

The specter of rationed medical care also has surfaced. I fully agree with rationing. Current medical technology too often enables us to spend 70% to 90% of a patient's lifetime medical expense in the last 2 weeks of his or her life. We have to face reality and agree when the end has arrived. Families who insist that physicians "give it all you've got" even when the physicians object should bear the costs of the patient's medical care.

Finally, inferior quality of medical care has been predicted in a nationalized system. It probably will occur. But it occurs now, because unlike robotics, wherein none will make or all will make the same mistake, we are still people, and people vary. The superior quality of medical care that all patients and physicians strive for cannot be guaranteed.

Miguel B. Banta, Jr, MD
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Upfront

ummit urges shift ward preventive ealth care

CHANGING SOCIETAL ATTITUDES to encourage healthier lifestyles, increasing the number of pri- ary care physicians, and increasing mmunization rates are among goals tablished April 23 at Texas Medical ssociation headquarters in Austin by blic and private sector groups seek- g to shift the focus of health-care elivery toward disease prevention d health promotion.

The recommendations were pro- uced by nearly 100 physicians, ate health and human services fficials, business leaders, voluntary ealth organization officials, con- mers, and others who participated "Summit 92: The Framework for lealthy Texans."

Sponsored by TMA, the summit rought public and private sector or- anizations together to finds ways to chieve national and state-level pub- c health and health education goals.

Key recommendations of the roup include initiating coordinated ampaigns to change societal atti- ides about their lifestyle choices.

"The leading causes of death are ot cancer, heart disease, stroke, and thers," said Sam A. Nixon, MD, en TMA president. "It's lifestyle hoices like tobacco, which accounts r 400,000 deaths in this country nnually; lifestyle choices like diet nd activity patterns, which result in 00,000 to 500,000 deaths; and al- ohol — at least 100,000 deaths. We eed to motivate Texans to protect heir own health."

Dr Nixon said these bad habits ot only result in illness and death, ut also directly impact the cost of ealth care. "The more unhealthy we are, the more health care and health insurance will cost all of us," he said.

Among key participants in "Summit 92: The Framework for Healthy Texans" at TMA April 23 were, from left, Laurance N. Nickey, MD, El Paso, chairman of the TMA Council on Public Health; Sen Chet Brooks (D-Pasadena); David Smith, MD, Austin, commissioner of the Texas Department of Health; and Sam A. Nixon, MD, Houston, who was TMA president at that time.

Participants also recommended measures to increase primary care manpower, improve trauma care, reduce violence, cut tobacco and alcohol use, and enhance prenatal care. They also proposed an action plan to move their recommendations forward through public and private sector efforts at the state and local levels.

Recommendations for increasing the number of primary care physicians include linking medical school funding to primary care programs and providing incentives for rural service. On immunizations, the group is calling for the state to assume liability for immunizations, with the state to purchase vaccines and distribute them to private physicians. Private physicians would be encouraged to volunteer their services to give immunizations to indigent populations.

Other specific recommendations include funding a statewide trauma system, strengthening drunken driving laws, dedicating alcohol and tobacco taxes for health-care services, and strengthening firearm regulations to prevent minors access to firearms.

David Smith, MD, Texas commissioner of health, stressed that a fundamental change in philosophy needs to be made if the focus is going to shift from curing disease to preventing it.

"You can pay me now or pay me later," Smith said. "We've got a 'pay me later' system right now. All of the incentives are for curative medicine, not prevention."

One of the "incentives" that must be looked at is payment for preventive services, Smith said. Presently, many private insurance policies and government programs do not pay for preventive services, such as immunizations or breast cancer screening.

"If we believe in this, we've got to be reinforcing it," he declared.

Dr Smith was one of several commissioners of state health, human services, and education agencies who participated in a panel discussion on public sector initiatives on prevention. Representatives of business and consumer groups examined private sector perspectives in a second panel discussion.

Insurance plan for Texas physicians makes major changes in HIV/AIDS coverages

THE BOARD OF TRUSTEES OF the Texas Medical Association Insurance Trust (TMAIT) recently voted to modify the definition of disability in its long-term disability and office overhead expense plans. The effect is to allow a Texas physician who is diagnosed as HIV positive to qualify immediately as totally disabled and able to draw benefits from both policies as long as he or she is no longer gainfully employed.

Previously, TMAIT, as well as most other insurance plans, did not provide for payments if the physician was still able to work.

In announcing this change, Ronald J. Pinkenburg, MD, chairman of the TMAIT board, said, "Our goal is to do what's right for both our physician member as well as the general public. This change will allow the physician who tests positive for HIV but who may not exhibit AIDS symptoms to leave the practice of medicine immediately without facing financial ruin or endangering their patients."

Dr Pinkenburg added that, to the board's knowledge, only a few insurance carriers offer any kind of HIV coverage and TMAIT is among the first to add this level of coverage as part of its policy.

Other HIV/AIDS policies offered by the insurance industry typically provide either a one-time lump sum benefit or monthly benefits after the insured provides satisfactory evidence of physical inability to continue his or her practice.

The TMAIT plan goes a step further by revising the definition of disability to include a positive HIV test along with the loss of gainful employment, regardless of the physical health of the insured. A physician insured by TMAIT would receive monthly benefits beginning with a positive HIV diagnosis, instead of only upon appearance of AIDS symptoms, which may not appear for several years following diagnosis of HIV infection. In addition, TMAIT will continue payments as defined in the TMAIT insurance brochure.

Since 1955, TMAIT has provided insurance to Texas physicians, their family members, and office staff. The trust is governed by a seven-member board of trustees, six of whom are physician members of Texas Medical Association; the seventh is the TMA executive vice president.

Training launches "Texas Physicians Speak Out!" campaign

A MAY 2 SPEECH AND MEDIA training session for TMA spokespersons kicked off the "Texas Physicians Speak Out!" (TPSO) campaign. The all-day training provided hands-on practice in effectively delivering a speech and in responding to media inquiries.

Initiated by the TMA Council on Communication and funded by the Board of Trustees, the TPSO campaign uses public relations strategies to enable physicians to speak out more aggressively and emphatically on issues of prime importance to members and their patients.

In addition to training, the campaign will include a pilot video to members. The video may be shown at county medical society meetings, as well as various locations within hospitals.

Based on research of county me ical society presidents and executiv and the TMA Hospital Medic Staff Section, the pilot video will b

- informative with emphasis on a vocacy, calls to action, and issu on the horizon;
- 5 to 10 minutes in length; and
- executed in a news format.

The pilot is scheduled to be r leased in late July.

Ready for whatever: TMA President William Gamel, MD

Kathryn Trombatore
Managing editor

CAUGHT BETWEEN A HECT morning of hospital roun and office patients and an a ternoon packed with meetings prepare for his tenure as TMA pres dent (which began May 16 William G. Gamel, MD, seems bo rushed and distracted.

But in response to a questic about his interest in politics, he r laxes into the sofa in the officer study at TMA headquarters Austin and smiles broadly.

"Politics is sort of like a che game," he says, his zest for compet tion apparent. "I like the intrigu playing the game, interacting wi other people — both adversarial ar friendly."

A former chairman of the TM Council on Legislation, he is we chosen to lead the association durir 1992–1993, a period that will i clude the Texas Legislature's "suns review" of the Medical Practice Act

He is fully aware of what tl sunset review could mean to phys

ans. With every law governing the ractice of medicine in Texas up for rutiny, some political watchers see 993 as a golden opportunity for ev- y "Doctor Wanna-be" in the state grab a piece of the patient.

Dr Gamel worries that many hysicians don't yet understand the reat.

"They know sunset is something at goes on in Austin," he says, "but don't think they're aware of what is really means for their practices, r the practice of medicine."

Physical therapists, chiropractors, sychologists, optometrists, nurse ractitioners, podiatrists, and other llied health practitioners all may etition the legislature for increased ghts in the next year.

Not, however, without opposition.

"This is the second time we've one through sunset," says Dr Gamel. Politically, we're in a much better osition than during 1981 for two ain reasons. One, we had never een through the process before 1981 was the first time the Medical ractice Act faced the sunset process]. wo, we conduct our political busi- ess differently than we did 12 years go. We're not really adversarial with lot of people, although we do have ur differences with various groups."

The strategy of maintaining lines f communication with potentially dversarial groups is one that TMA as adopted with vigor in the past 6 ears. To Dr Gamel, being able to alk to a lot of those groups and ome to an understanding with them enefits not only physicians, but heir patients, too.

"We've talked to an awful lot of roups I thought we'd never be able o talk to," he says. "Talking doesn't urt anything. We're not always ight and they're not always wrong. What we must keep uppermost in our minds are the dual needs of defending the quality of medicine and improving access to it."

Seeing the struggles up close

Dr Gamel knows first hand the daily difficulties that confront physicians trying to maintain the high quality of medicine. A member of an Austin group of four gastroenterologists, Dr Gamel has been with the practice since 1967 — and plans to remain an active member during his presidential year.

William G. Gamel, MD, was installed May 16 as TMA president for 1992–1993 during the 1992 TMA Annual Session in San Antonio.

He says his struggles with Medicare reforms, the Medicare cuts that hurt his practice, and other day-to-day regulatory hassles mean that he really understands what physicians across Texas face.

"I think it's important for physicians to realize that you can maintain a practice *and* be involved in organized medicine," he says. "I'm going to be a working physician as president of the TMA. Of course there will be some accommodations, but basically I'm going to maintain my practice, see patients, and take my call, just like my associates."

A native of Lampasas, Dr Gamel finished high school in a class of 72 people, already intent upon becoming a physician.

"I wanted to be a physician for so long that I really can't remember when I decided," he says. "I was probably around 12 or 13 years of age when I set that as my goal and I never really strayed from it."

He received his undergraduate degree from The University of Texas at Austin and his medical degree from The University of Texas Medical Branch at Galveston. He served an internship and residency in internal medicine at Parkland Memorial Hospital in Dallas.

Dr Gamel and his wife, Nancy, have three children. Their son, Chris, and daughter, Susan Donnelly, live in Houston; Bill Jr lives in Austin.

Prior to serving on the Council on Legislation from 1982 through 1991, Dr Gamel briefly served on the now-defunct Committee on Orientation. His active involvement in organized medicine began in 1974 when he was appointed to the Committee on Association Insurance Programs, which he chaired from 1980 to 1982. He also served as a consultant to the Committee on Professional Liability from 1984 to 1991.

He is a past president of the Travis County Medical Society and past president of the medical staff at St David's Community Hospital in Austin. He also serves as an alternate delegate to the AMA House of Delegates and is a former delegate to the TMA House.

He is a past president of the Central Texas Regional Blood Center

and member of the board of the Texas Society of Internal Medicine.

Fighting apathy

Given the degree of enthusiasm that Dr Gamel feels for politics, it is surprising that he had not always been politically involved.

"I had never been active in the political arena in any way until I got involved in the Council on Legislation and also served on the TEXPAC board," says Dr Gamel. "That was a good education for me. Being exposed to Washington and Austin politics really crystallized for me the issues — good, bad, and indifferent — that medicine has to face. It's a critical time for medicine, given what's happening on the national scene and at the state level."

What's needed, he says, is more physician involvement. But the general feeling of many physicians is that nothing much can be done.

"I sense a bit of fatalism and cynicism about politics on the part of physicians, and I find that sometimes true of myself," he says. "But it's apathy that we have to fight against — the resignation that there's nothing we can do — because there *is* something we can do. We have to continue to teach politicians and regulators about what it means to be in the trenches, taking care of people every day."

To Dr Gamel, one of the biggest threats to the medical profession is that politicians seem too ready to sacrifice quality medicine for political expediency.

"People talk about dollars as if they should drive everything we do in medicine. That's shortsighted. Not that we shouldn't have cost-effective, available, accessible health care for everyone. But let's not lose sight of quality. Talking exclusively about how cheaply we can do everything is dangerous," he says.

Speaking out for quality

Being a spokesman for quality is one role Dr Gamel is likely to play during his presidential year.

"I'd like to communicate to the politicians and regulators about how we must preserve the high quality of American medicine," he says. "They must not burden physicians down with such onerous kinds of interference that they drive good quality people out of medicine. We've got to attract the brightest and best to medicine if we're going to maintain the quality."

He also is looking forward to meeting physicians across the state.

"I would like to offer myself to Texas physicians who have a concern that they want to communicate with me through the TMA," he says. "I will try my very best to respond to them. I'd like to be sensitive to their needs and wants and represent their feelings and desires for the profession."

But Dr Gamel doesn't want his colleagues to expect him to be limited to a single "theme" during his presidential year.

"To be honest with you, I don't have a theme. I don't have a sound bite or a cute phrase or anything of that sort," he says.

Instead he just plans to be ready to deal with whatever comes along that threatens Texas physicians' ability to practice quality medicine.

And what he wants from his colleagues is for them to be informed, "to be a part of the team from the top to the bottom" by membership in their county society, the TMA, and the AMA. ★

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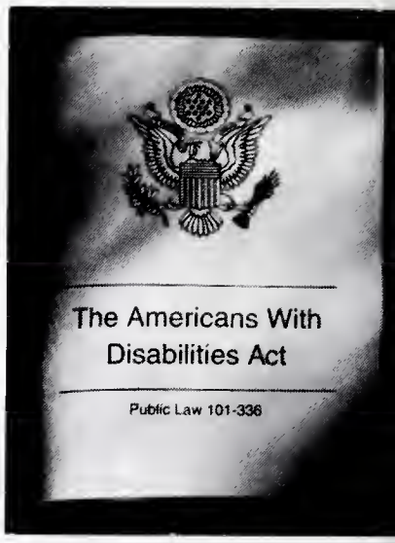

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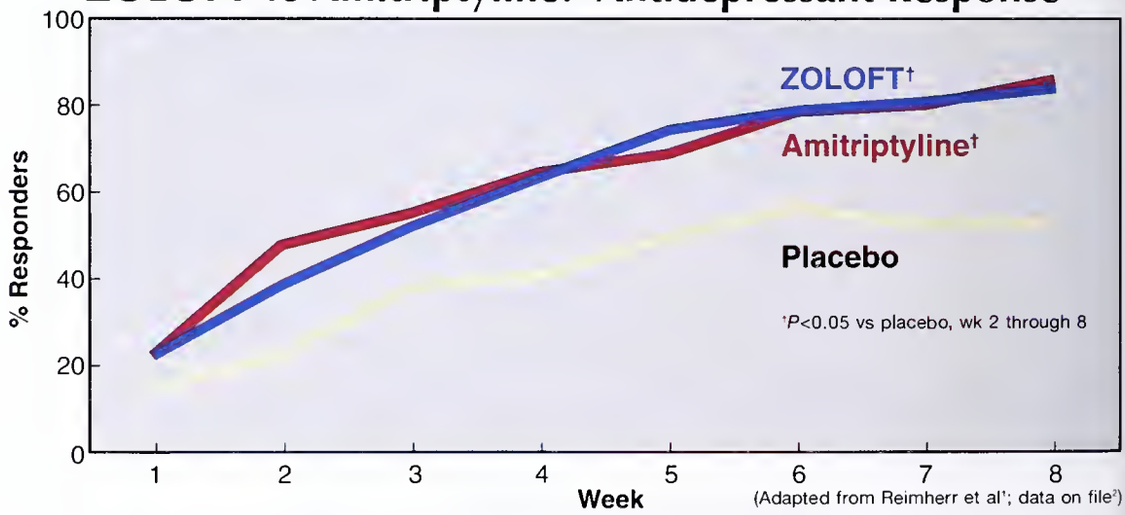
ZOLOFT vs Amitriptyline: Antidepressant Response*[1,2]



(Adapted from Reimherr et al[1]; data on file[2])

*Observed cases, evaluable patients (ie, patients who took drug on or after double-blind treatment day 11 and who had efficacy evaluations within that same time frame); response is defined as a CGI-Improvement score of 1 (very much improved) or 2 (much improved) at time point. Patient numbers for each regimen: ZOLOFT—wk 1=117, wk 2=120, wk 3=106, wk 4=98, wk 5=93, wk 6=94, wk 7=83, wk 8=80; amitriptyline—wk 1=116, wk 2=113, wk 3=111, wk 4=104, wk 5=102, wk 6=92, wk 7=89, wk 8=76; placebo—wk 1=124, wk 2=120, wk 3=116, wk 4=108, wk 5=97, wk 6=89, wk 7=94, wk 8=85.

Double-blind, multicenter, placebo-controlled, parallel study of antidepressant effects of ZOLOFT vs amitriptyline in 448 subjects who met DSM-III criteria for major depression. Symptoms were assessed after a single-blind, 7-day to 14-day placebo washout. Patients were randomly assigned to ZOLOFT, amitriptyline, or placebo for 8 wk. Daily dosage ranges: ZOLOFT—50-200 mg; amitriptyline—50-150 mg.

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ZOLOFT...Effective Continuation Therapy[2,3]

- Responders to ZOLOFT during an 8-week acute-treatment phase were randomized to continue on ZOLOFT or placebo
- A significantly lower relapse rate* was observed for patients treated with ZOLOFT compared with those on placebo, in an assessment of the first 8 weeks of the continuation period
- The effectiveness of ZOLOFT has not been systematically evaluated in long-term use for more than 16 weeks

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*Relapsing patients were those who became ill (CGI-Severity score ≥4 at any visit) during the double-blind continuation phase and who remained ill during the rest of their time in the study.

Responders in an 8-wk, open-label, acute-treatment study entered a double-blind continuation phase and were randomized to ZOLOFT or placebo. ZOLOFT daily dosage range: 50-200 mg.

References: 1. Reimherr FW, Chouinard G, Cohn CK, et al. Antidepressant efficacy of sertraline: a double-blind, placebo- and amitriptyline-controlled, multicenter comparison study in outpatients with major depression. *J Clin Psychiatry.* 1990;51(12, suppl B):18-27. **2.** Data on file. Pfizer Inc, New York, NY. **3.** Doogan DP, Caillard V. Sertraline in the prevention of depression. *Br J Psychiatry.* 1992;160:217-222.

Please see brief summary of prescribing information on adjacent page.

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(sertraline HCl) 50 mg, 100 mg scored tablets

BRIEF SUMMARY

ZOLOFT™ (sertraline HCl)

INDICATIONS AND USAGE: ZOLOFT (sertraline hydrochloride) is indicated for the treatment of depression.

CONTRAINDICATIONS: None known. **WARNINGS: In patients receiving another serotonin reuptake inhibitor drug in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued that drug and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Therefore, it is recommended that ZOLOFT (sertraline hydrochloride) not be used in combination with an MAOI, or within 14 days of discontinuing treatment with an MAOI. Similarly, at least 14 days should be allowed after stopping ZOLOFT before starting an MAOI.** **PRECAUTIONS** ***General:*** **Activation of Mania/Hypomania** - During premarketing testing, hypomania or mania occurred in approximately 0.4% of ZOLOFT (sertraline hydrochloride) treated patients. Activation of mania/hypomania has also been reported in a small proportion of patients with Major Affective Disorder treated with other marketed antidepressants. **Weight Loss** - Significant weight loss may be an undesirable result of treatment with sertraline for some patients, but on average, patients in controlled trials had minimal, 1 to 2 pound weight loss, versus smaller changes on placebo. Only rarely have sertraline patients been discontinued for weight loss. **Seizure** - ZOLOFT has not been evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarket testing. Accordingly, like other antidepressants, ZOLOFT should be introduced with care in epileptic patients. **Suicide** - The possibility of a suicide attempt is inherent in depression and may persist until significant remission occurs. Close supervision of high risk patients should accompany initial drug therapy. Prescriptions for ZOLOFT should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. **Weak Uricosuric Effect** - ZOLOFT is associated with a mean decrease in serum uric acid of approximately 7%. The clinical significance of this weak uricosuric effect is unknown, and there have been no reports of acute renal failure with ZOLOFT. **Use in Patients with Concomitant Illness** - Clinical experience with ZOLOFT in patients with certain concomitant systemic illness is limited. Caution is advisable in using ZOLOFT in patients with diseases or conditions that could affect metabolism or hemodynamic responses. ZOLOFT has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from clinical studies during the product's premarket testing. However, the electrocardiograms of 774 patients who received ZOLOFT in double-blind trials were evaluated and the data indicate that ZOLOFT is not associated with the development of significant ECG abnormalities. ZOLOFT is extensively metabolized by the liver. The pharmacokinetics of ZOLOFT have not been studied in patients with significant hepatic dysfunction nor have patients with significant hepatic dysfunction been evaluated during treatment with ZOLOFT. Accordingly, ZOLOFT should be used with caution in such patients. Since ZOLOFT is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. However, until the pharmacokinetics of ZOLOFT have been studied in patients with renal impairment and until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with ZOLOFT, it should be used with caution in such patients. **Interference with Cognitive and Motor Performance** - In controlled studies, ZOLOFT did not cause sedation and did not interfere with psychomotor performance. ***Information for Patients:*** Physicians are advised to discuss the following issues with patients for whom they prescribe ZOLOFT: Patients should be told that although ZOLOFT has not been shown to impair the ability of normal subjects to perform tasks requiring complex motor and mental skills in laboratory experiments, drugs that act upon the central nervous system may affect some individuals adversely. Patients should be told that although ZOLOFT has not been shown in experiments with normal subjects to increase the mental and motor skill impairments caused by alcohol, the concomitant use of ZOLOFT and alcohol in depressed patients is not advised. Patients should be told that while no adverse interaction of ZOLOFT with over-the-counter (OTC) drug products is known to occur, the potential for interaction exists. Thus, the use of any OTC product should be initiated cautiously according to the directions of use given for the OTC product. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. Patients should be advised to notify their physician if they are breast-feeding an infant. ***Laboratory Tests:*** None. ***Drug Interactions:*** **Potential Effects of Coadministration of Drugs Highly Bound to Plasma Proteins** - Because sertraline is tightly bound to plasma protein, the administration of ZOLOFT (sertraline hydrochloride) to a patient taking another drug which is tightly bound to protein (e.g., warfarin, digitoxin) may cause a shift in plasma concentrations potentially resulting in an adverse effect. Conversely, adverse effects may result from displacement of protein-bound ZOLOFT by other tightly bound drugs. In a study comparing prothrombin time AUC (0-120 hr) following dosing with warfarin (0.75 mg/kg) before and after 21 days of dosing with either ZOLOFT (50-200 mg/day) or placebo, there was a mean increase in prothrombin time of 8% relative to baseline for ZOLOFT compared to a 1% decrease for placebo ($p<0.02$). The normalization of prothrombin time for the ZOLOFT group was delayed compared to the placebo group. The clinical significance of this change is unknown. Accordingly, prothrombin time should be carefully monitored when ZOLOFT therapy is initiated or stopped. **CNS Active Drugs** - In a study comparing the disposition of intravenously administered diazepam before and after 21 days of dosing with either ZOLOFT (50 to 200 mg/day escalating dose) or placebo, there was a 32% decrease relative to baseline in diazepam clearance for the ZOLOFT group compared to a 19% decrease relative to baseline for the placebo group ($p<0.03$). There was a 23% increase in T_{max} for desmethyldiazepam in the ZOLOFT group compared to a 20% decrease in the placebo group ($p<0.03$). The clinical significance of these changes is unknown. In a placebo-controlled trial in normal volunteers, the administration of two doses of ZOLOFT did not significantly alter steady-state lithium levels or the renal clearance of lithium. Nonetheless, at this time, it is recommended that plasma lithium levels be monitored following initiation of ZOLOFT therapy with appropriate adjustments to the lithium dose. The risk of using ZOLOFT in combination with other CNS active drugs has not been systematically evaluated. Consequently, caution is advised if the concomitant administration of ZOLOFT and such drugs is required. **Hypoglycemic Drugs** - In a placebo-controlled trial in normal volunteers, administration of ZOLOFT for 22 days (including 200 mg/day for the final 13 days) caused a statistically significant 16% decrease from baseline in the clearance of tolbutamide following an intravenous 1000 mg dose. ZOLOFT administration did not noticeably change either the plasma protein binding or the apparent volume of distribution of tolbutamide, suggesting that the decreased clearance was due to a change in the metabolism of the drug. The clinical significance of this decrease in tolbutamide clearance is unknown. **Atenolol** - ZOLOFT (100 mg) when administered to 10 healthy male subjects had no effect on the beta-adrenergic blocking ability of atenolol. **Microsomal Enzyme Induction** - Preclinical studies have shown ZOLOFT to induce hepatic microsomal enzymes. In clinical studies ZOLOFT was shown to induce hepatic enzymes minimally as determined by a small (5%) but statistically significant decrease in antipyrine half-life following administration of 200 mg/day for 21 days. This small change in antipyrine half-life reflects a clinically insignificant change in hepatic metabolism. **Electroconvulsive Therapy** - There are no clinical studies establishing the risks or benefits of the combined use of electroconvulsive therapy (ECT) and ZOLOFT. **Alcohol** - Although ZOLOFT did not potentiate the cognitive and psychomotor effects of alcohol in experiments with normal subjects, the concomitant use of ZOLOFT and alcohol in depressed patients is not recommended. ***Carcinogenesis, Mutagenesis, Impairment of Fertility:*** Lifetime carcinogenicity studies were carried out in CD-1 mice and Long-Evans rats at doses up to 40 mg/kg in mice (10 times on a mg/kg basis and the same on a mg/m^2 basis as the maximum recommended human dose) and at doses up to 40 mg/kg in rats (10 times on a mg/kg basis and 2 times on a mg/m^2 basis, the maximum recommended human dose). There was a dose-related increase in the incidence of liver adenomas in male mice receiving sertraline at 10-40 mg/kg. No increase was seen in female mice or in rats of either sex receiving the same treatments, nor was there an increase in hepatocellular carcinomas. Liver adenomas have a variable rate of spontaneous occurrence in the CD-1 mouse and are of unknown significance to humans. There was an increase in follicular adenomas of the thyroid in female rats receiving sertraline at 40 mg/kg; this was not accompanied by thyroid hyperplasia. While there was an increase in uterine adenocarcinomas in rats receiving sertraline at 10-40 mg/kg compared to placebo controls, this effect was not clearly drug related. Sertraline had no genotoxic effects, with or without metabolic activation, based on the following assays: bacterial mutation assay; mouse lymphoma mutation assay; and tests for cytogenetic aberrations *in vivo* in mouse bone marrow and *in vitro* in human lymphocytes. A decrease in fertility was seen in one of two rat studies at a dose of 80 mg/kg (20 times the maximum human dose on a mg/kg basis and 4 times on a mg/m^2 basis). ***Pregnancy—Pregnancy Category B:*** **Teratogenic Effects** - Reproduction studies have been performed in rats and rabbits at doses up to approximately 20 times and 10 times the maximum daily human mg/kg dose (4 to 4.5 times the mg/m^2 dose), respectively. There was no evidence of teratogenicity at any dose level. At doses approximately 2.5-10 times the maximum daily human mg/kg dose, sertraline was associated with delayed ossification in fetuses, probably secondary to effects on the dams. There are no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed. **Non-teratogenic Effects** - There was also decreased neonatal survival following maternal administration of sertraline at doses as low as approximately 5 times the maximum human mg/kg dose. The decrease in pup survival was shown to be most probably due to *in utero* exposure to sertraline. The clinical significance of these effects is unknown. **Labor and Delivery** - The effect of ZOLOFT on labor and delivery in humans is unknown. **Nursing Mothers** - It is not known whether, and if so in what amount, sertraline or its metabolites are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when ZOLOFT is administered to a nursing woman. **Pediatric Use** - Safety and effectiveness in children have not been established. **Geriatric Use** - Several hundred elderly patients have participated in clinical studies with ZOLOFT. The pattern of adverse reactions in the elderly was similar to that in younger patients. **ADVERSE REACTIONS** ***Commonly Observed:*** The most commonly observed adverse events associated with the use of ZOLOFT (sertraline hydrochloride) and not seen at an equivalent incidence among placebo-treated patients were: gastrointestinal complaints including nausea, diarrhea/loose stools and dyspepsia; tremor; dizziness; insomnia; somnolence; increased sweating; dry mouth and male sexual dysfunction (primarily ejaculatory delay). ***Associated with Discontinuation of Treatment:*** Fifteen percent of 2710 subjects who received ZOLOFT in premarketing multiple dose clinical trials discontinued treatment due to an adverse event. The more common events (reported by at least 1% of subjects) associated with discontinuation included agitation, insomnia, male sexual dysfunction (primarily ejaculatory delay), somnolence, dizziness, headache, tremor, anorexia, diarrhea/loose stools, nausea, and fatigue. ***Incidence in Controlled Clinical Trials:*** The table that follows enumerates adverse events that occurred at a frequency of 1% or more among ZOLOFT patients who participated in controlled trials comparing titrated ZOLOFT with placebo. Most patients received doses of 50 to 200 mg per day.

Treatment-Emergent Adverse Experience Incidence in Placebo-Controlled Clinical Trials*

Adverse Experience	ZOLOFT (N=861) (Percent of Patients Reporting)	Placebo (N=853) (Percent of Patients Reporting)
Autonomic Nervous System Disorders		
Mouth Dry	16.3	9.3
Sweating Increased	8.4	2.9
Cardiovascular		
Palpitations	3.5	1.6
Chest Pain	1.0	1.6
Central and Peripheral Nervous System Disorders		
Headache	20.3	19.0
Dizziness	11.7	6.7
Tremor	10.7	2.7
Paresthesia	2.0	1.8
Hypoesthesia	1.7	0.6
Twitching	1.4	0.1
Hypertonia	1.3	0.4
Disorders of Skin and Appendages		
Rash	2.1	1.5
Gastrointestinal Disorders		
Nausea	26.1	11.8
Diarrhea/Loose Stools	17.7	9.3
Constipation	8.4	6.3
Dyspepsia	6.0	2.8
Vomiting	3.8	1.8
Flatulence	3.3	2.5
Anorexia	2.8	1.6
Abdominal Pain	2.4	2.2
Appetite Increased	1.3	0.9
General		
Fatigue	10.6	8.1
Hot Flushes	2.2	0.5
Fever	1.6	0.6
Back Pain	1.5	0.9
Metabolic and Nutritional Disorders		
Thirst	1.4	0.9
Musculoskeletal System Disorders		
Myalgia	1.7	1.5
Psychiatric Disorders		
Insomnia	16.4	8.8
Sexual Dysfunction-Male (1)	15.5	2.2
Somnolence	13.4	5.9
Agitation	5.6	4.0
Nervousness	3.4	1.9
Anxiety	2.6	1.3
Yawning	1.9	0.2
Sexual Dysfunction-Female (2)	1.7	0.2
Concentration Impaired	1.3	0.5
Reproductive		
Menstrual Disorder (2)	1.0	0.5
Respiratory System Disorders		
Rhinitis	2.0	1.5
Pharyngitis	1.2	0.9
Special Senses		
Vision Abnormal	4.2	2.1
Tinnitus	1.4	1.1
Taste Perversion	1.2	0.7
Urinary System Disorders		
Micturition Frequency	2.0	1.2
Micturition Disorder	1.4	0.5

*Events reported by at least 1% of patients treated with ZOLOFT are included.
(1) - % based on male patients only: 271 ZOLOFT (primarily ejaculatory delay) and 271 placebo patients.
(2) - % based on female patients only: 590 ZOLOFT and 582 placebo patients.

Other Events Observed During the Premarketing Evaluation of ZOLOFT (sertraline hydrochloride): During its premarketing assessment, multiple doses of ZOLOFT were administered to approximately 2700 subjects. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients (only those not already listed in the tabulated results from placebo-controlled trials appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. Events of major clinical importance are also described in the PRECAUTIONS section. **Autonomic Nervous System Disorders**—*Infrequent:* flushing, mydriasis, increased salivation, cold clammy skin; *Rare:* pallor. **Cardiovascular**—*Infrequent.* postural dizziness, hypertension, hypotension, postural hypotension, edema, dependent edema, periorbital edema, peripheral edema, peripheral ischemia, syncope, tachycardia; *Rare:* precordial chest pain, substernal chest pain, aggravated hypertension, myocardial infarction, varicose veins. **Central and Peripheral Nervous System Disorders**—*Frequent.* confusion; *Infrequent:* ataxia, abnormal coordination, abnormal gait, hyperesthesia, hyperkinesia, hypokinesia, migraine, nystagmus, vertigo; *Rare:* local anesthesia, coma, convulsions, dyskinesia, dysphonia, hyporeflexia, hypotonia, ptosis. **Disorders of Skin and Appendages**—*Infrequent:* acne, alopecia, pruritus, erythematous rash, maculopapular rash, dry skin; *Rare:* bullous eruption, dermatitis, erythema multiforme, abnormal hair texture, hypertrichosis, photosensitivity reaction, follicular rash, skin discoloration, abnormal skin odor, urticaria. **Endocrine Disorders**—*Rare:* exophthalmos, gynecomastia. **Gastrointestinal Disorders**—*Infrequent:* dysphagia, eructation; *Rare:* diverticulitis, fecal incontinence, gastritis, gastroenteritis, glossitis, gum hyperplasia, hemorrhoids, hiccup, melena, hemorrhagic peptic ulcer, proctitis, stomatitis, ulcerative stomatitis, tenesmus, tongue edema, tongue ulceration. **General**—*Frequent:* asthenia; *Infrequent:* malaise, generalized edema, rigors, weight decrease, weight increase; *Rare:* enlarged abdomen, halitosis, otitis media, aphthous stomatitis. **Hematopoietic and Lymphatic**—*Infrequent:* lymphadenopathy, purpura; *Rare:* anemia, anterior chamber eye hemorrhage. **Metabolic and Nutritional Disorders**—*Rare:* dehydration, hypercholesterolemia, hyperglycemia. **Musculoskeletal System Disorders**—*Infrequent:* arthralgia, arthrosis, dystonia, muscle cramps, muscle weakness; *Rare:* hernia. **Psychiatric Disorders**—*Infrequent:* abnormal dreams, aggressive reaction, amnesia, apathy, delusions, depersonalization, depression, aggravated depression, emotional lability, euphoria, hallucination, neurosis, paranoid reaction, suicide ideation and attempt, teeth-grinding, abnormal thinking; *Rare:* hysteria, somnambulism, withdrawal syndrome. **Reproductive**—*Infrequent:* dysmenorrhea (2), intermenstrual bleeding (2); *Rare:* amenorrhea (2), balanoposthitis (1), breast enlargement (2), female breast pain (2), leukorrhea (2), menorrhagia (2), atrophic vaginitis (2).

(1) - % based on male subjects only: 1005; (2) - % based on female subjects only: 1705.

Respiratory System Disorders—*Infrequent:* bronchospasm, coughing, dyspnea, epistaxis; *Rare:* bradypnea, hyperventilation, sinusitis, stridor. **Special Senses**—*Infrequent:* abnormal accommodation, conjunctivitis, diplopia, earache, eye pain, xerophthalmia; *Rare:* abnormal lacrimation, photophobia, visual field defect. **Urinary System Disorders**—*Infrequent:* dysuria, face edema, nocturia, polyuria, urinary incontinence; *Rare:* oliguria, renal pain, urinary retention. **Laboratory Tests** In man, asymptomatic elevations in serum transaminases (SGOT [or AST] and SGPT [or ALT]) have been reported infrequently (approximately 0.8%) in association with ZOLOFT administration. These hepatic enzyme elevations usually occurred within the first 1 to 9 weeks of drug treatment and promptly diminished upon drug discontinuation. ZOLOFT therapy was associated with small mean increases in total cholesterol (approximately 3%) and triglycerides (approximately 5%), and a small mean decrease in serum uric acid (approximately 7%) of no apparent clinical importance. **DRUG ABUSE AND DEPENDENCE** ***Controlled Substance Class*** - ZOLOFT (sertraline hydrochloride) is not a controlled substance. ***Physical and Psychological Dependence*** - ZOLOFT has not been systematically studied, in animals or humans, for its potential for abuse, tolerance, or physical dependence. However, the premarketing clinical experience with ZOLOFT did not reveal any tendency for a withdrawal syndrome or any drug-seeking behavior. As with any new CNS active drug, physicians should carefully evaluate patients for history of drug abuse and follow such patients closely, observing them for signs of ZOLOFT misuse or abuse (e.g., development of tolerance, incrementation of dose, drug-seeking behavior). **OVERDOSAGE** ***Human Experience*** - There have been 3 cases of ZOLOFT (sertraline hydrochloride) overdosage (approximately 750-2,100 mg). No specific therapy was required for any of the 3 patients, all of whom recovered completely. ***Management of Overdoses*** - Establish and maintain an airway, insure adequate oxygenation and ventilation. Activated charcoal, which may be used with sorbitol, may be as or more effective than emesis or lavage, which should be considered in treating overdose. Cardiac and vital signs monitoring is recommended along with general symptomatic and supportive measures. There are no specific antidotes for ZOLOFT. Due to the large volume of distribution of ZOLOFT, forced diuresis, dialysis, hemoperfusion, and exchange transfusion are unlikely to be of benefit. In managing overdosage, consider the possibility of multiple drug involvement. The physician should consider contacting a poison control center on the treatment of any overdose.

Pfizer

Roerig
Pratt
Pharmaceuticals

People

NEWSMAKERS

rofessor and chairman of radiation ıerapy at The University of Texas Iedical Branch at Galveston, **James A. elli, MD,** was sworn in as president of ıe Radiation Research Society during 's annual meeting. The society, a ʼorldwide, nonprofit organization, proıotes original research and facilitates ıe integration and dissemination of nowledge in radiation-related fields.

'he Society of Thoracic Surgeons se-ɛcted **Denton Cooley, MD,** surgeon-inhief of the Texas Heart Institute in Iouston, as president-elect of the ,000-member organization. Dr Coo-ɛy will take office in January 1993.

'he Southern Medical Association onored family practitioner **P.T. ichelberger, MD,** and orthopedic surɛon **Charles George, MD,** for their reɔective 35 years of medical service. ach received a plaque during "Docɔrs' Day" ceremonies in Baytown.

avid N. Herndon, MD, chief of staff of ıe Shriners Burns Institute and diɛctor of burn services at The Uniɛrsity of Texas Medical Branch at ;alveston, was chosen for a 1-year ɛrm as president of the Society of Iniversity Surgeons. Dr Herndon reviously served as treasurer and ouncilman-at-large for the society.

ease let *Texas Medicine* know about your nors and achievements.

iteria for inclusion in the Newsmakers secɔn are: TMA member; election or appointɛnt to an office of, or honors from, a nation- or state organization; or, space permitting, ɛognition at the local level. Items for the ʼwsmakers section are published at the disɛtion of the managing editor. Submit items r consideration, with photos if possible, to ʼople, Texas Medicine, *401 W 15th St, ıstin, TX 78701.*

Robert E. Jordon, MD, chairman of dermatology at The University of Texas Medical School at Houston, was elected chairman of the National Advisory Board for the National Institute of Arthritis, Musculoskeletal and Skin Diseases.

Emergency medicine specialist and director of Tri-Star Medical Services, **Regina F. Kyles, MD,** was honored as one of two "Super Young Achievers of the Year" at the 13th Human Enrichment Award Dinner, which salutes the Young Black Achievers of Houston.

McAllen thoracic surgeon **Jesus Rodriguez, MD,** is the first recipient of the Hidalgo-Starr County Medical Society Distinguished Physician Award for 1992. He was chosen for this award for his involvement in improving health care in the county and his service to indigent patients. **Dr Rodriguez** was also instrumental in bringing a cancer center to McAllen.

Austin pediatrician **Karen Teel, MD,** received the first Award of Distinction in Bioethics by the International Bioethics Institute. **Dr Teel** pioneered the model of hospital-based bioethics committees, which assist patients, families, physicians, and other professionals in making ethical and humane choices about the end of life.

Mark L. Winter, MD, Lubbock, was appointed to the National and International Standards Committee of the American Academy of Otolaryngology Head and Neck Surgery.

OBITUARIES

Edward D. Dumas, MD, 93; San Antonio; Tulane University, 1921; died February 24, 1992.

Clyde F. Elkins, MD, 80; Lubbock; The University of Texas Medical Branch at Galveston, 1936; died January 31, 1992.

J.L. Fenlaw, MD, 79; Gilmer; Baylor College of Medicine, 1937; died March 10, 1992.

Joseph H. Greenwood, MD, 83; Temple; The University of Texas Medical Branch at Galveston, 1934; died March 30, 1992.

George D. Kiperman, MD, 62; Houston; University of Buenos Aires, 1956; died March 6, 1992.

Yoshio Miyazaki, MD, 55; Corpus Christi; Hahnemann Medical College of Philadelphia, 1982; died March 21, 1992.

Virginia L. Moreland, MD, 71; Dallas; The University of Illinois Medical School, 1950; died March 18, 1992.

Marvin C. Overton, MD, 88; Amarillo; Baylor College of Medicine, 1929; died February 24, 1992.

B. Brian Parrish, MD, 45; Houston; The University of Texas Medical Branch at Galveston, 1972; died March 16, 1992.

Jay W. Powell, MD, 63; Irving; The University of Texas Health Science Center at Dallas, 1957; died March 26, 1992.

Arthur Hannon Propst, DO, 43; Princeton; Texas College of Osteopathic Medicine, 1976; died March 13, 1992.

Nicholas Rodriguez, MD, 68; Beaumont; University of Havana Medical School, 1950; died March 26, 1992.

Anthony B. Seidenberg, MD, 49; Austin; University of California at San Francisco Medical School, 1969; died March 16, 1992.

John H. Scott, MD, 73; El Paso; University of Oklahoma Health Sciences Center, 1973; reported deceased.

John Stuart Scott, DO, 34; Lubbock; Texas College of Osteopathic Medicine, 1985; reported deceased.

Walter A. Sievers, MD, 87; Gonzales; The University of Texas Medical Branch at Galveston, 1932; died March 18, 1992.

Byron E. Strug, MD, 51; Houston; Louisiana State University Medical Center, 1964; died March 24, 1992.

Sylvester W. Thorn, Jr, MD, 80; Houston; University of Tennessee Center for Health Sciences, 1936; died March 11, 1992.

James N. Walker, MD, 77; Hurst; The University of Texas Medical Branch at Galveston, 1942; died March 31, 1992.

Elsayed A. Zein-Eldin, MD, 67; Galveston; The University of Texas Medical Branch at Galveston, 1965; died April 6, 1992.

FORMER TMA PRESIDENT MAX E. JOHNSON, MD, DIES

MAX E. JOHNSON, MD, president of Texas Medical Association during 1964–1965, died April 9, 1992. He was 91.

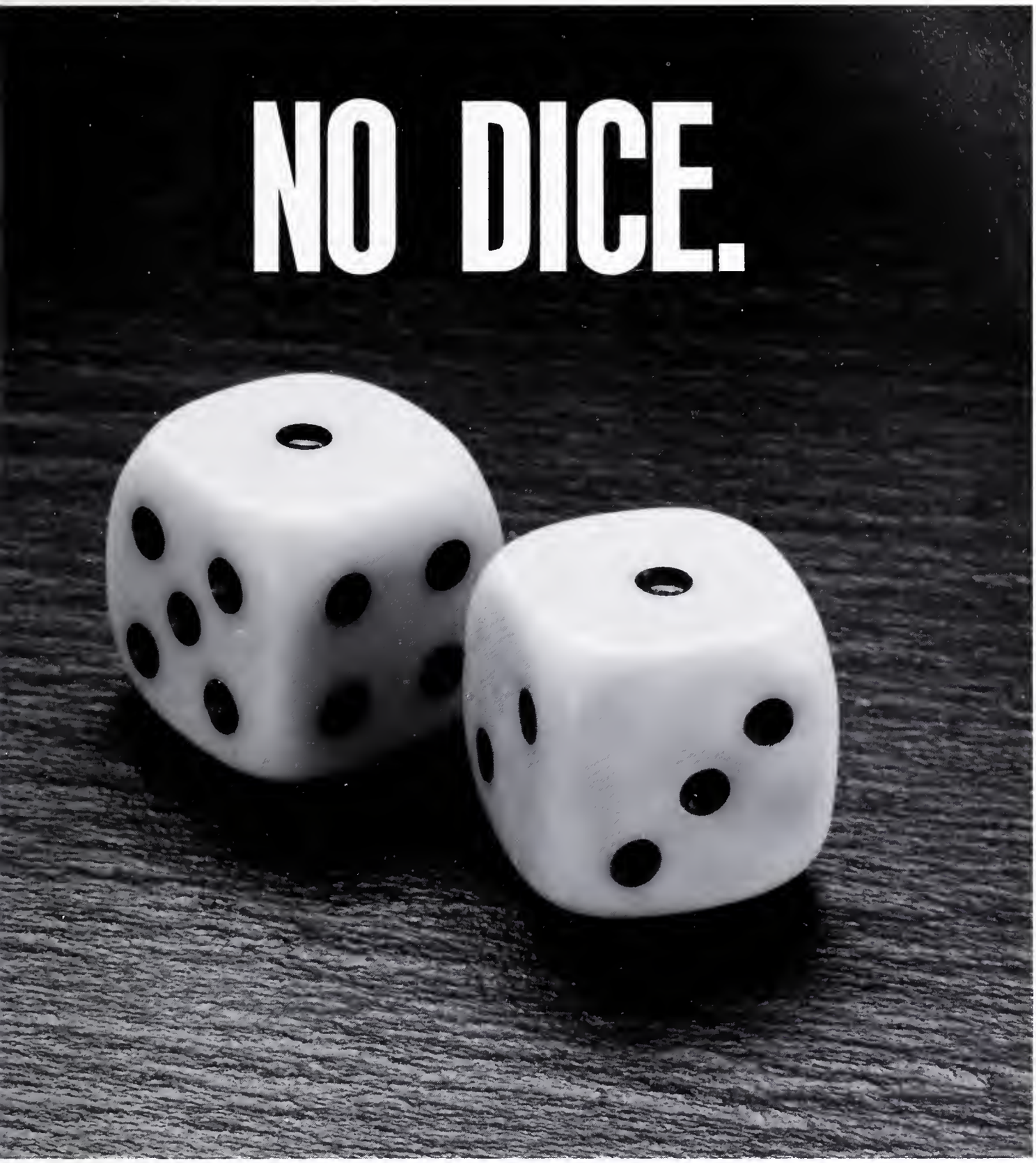
A retired San Antonio general practitioner, Dr Johnson was an emeritus member of TMA who had been active in both TMA and the American Medical Association since 1925. He also was a charter member of the Texas Medical Association Political Action Committee and served as its chairman during 1962–1963. Dr Johnson held numerous appointments on TMA committees and councils, and was a member of the AMA Committee on Nursing during the mid-1960s. He served as president of Bexar County Medical Society in 1963.

He also held various civic and scouting posts in his community, including serving on the San Antonio City Council from 1958 to 1961. Referring to his community service, he was quoted in a 1964 *Texas Medicine* article: "It is not enough for a doctor to be a good physician; he must also be a good citizen, taking an active part in the religious, civic, social, and political life of his community."

Born in Wilson County, Texas, Dr Johnson practiced medicine in San Antonio for more than 40 years. He graduated in 1924 from The University of Texas Medical Branch at Galveston and interned at Robert B. Green Memorial Hospital in San Antonio. He selected general medicine because he believed it offered the only means of being a personal physician to all members of a family. Dr Johnson also served as a major in the US Army Air Force during World War II.

He is survived by his wife, Elizabeth Johnson, San Antonio; sons, Douglas E. Johnson, MD, Houston, and E. Milton Johnson, San Antonio; a daughter, Mrs. James C. Anderson, San Antonio; a brother, Ted Johnson, MD, San Antonio; and grandchildren and great-grandchildren.

NO DICE.



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(806) 796-7208

Medical Economics

Here's help in understanding Medicare's new claim form

AMONG THE PROFUSION of major changes in Medicare that physicians must cope with this year is a revised HCFA 1500 form (see facing page), which must be used beginning July 1 to file claims. (The original deadline for switching to the new form was May 1, 1992. In an 11th-hour reprieve on April 30, the American Medical Association won a delay from the Health Care Financing Administration.)

Medicare will no longer accept "superbills" after June 30, and in addition, is likely to reject any HCFA 1500 forms that are not filled out to Medicare's specifications. According to experts in TMA's health-care financing department, submitting a properly filled out form requires attention to detail, neatness, accuracy, and completeness. They offer the following advice:

- First, be certain that you have the proper version of the form. Check the lower right corner for "Form HCFA-1500 (U2) (12-90)." Some forms have a bar code at the top left, others do not. Blue Cross and Blue Shield of Texas, the state's Medicare carrier, does not currently require a bar code on its forms, but said that as it automates processing in the future, that policy may change. (The sample copy shown here does not contain the bar code.) Do not send photocopies of the form; always use the original version printed in red ink.
- In general, include *all* claim information on the HCFA 1500 form. Do not send a form with attachments or additional materials for which there is a space to provide that information. Only attach extra material when it is needed to further explain information on the form.
- Medicare prefers that forms not be stapled and contain no highlighting or other extraneous marks.
- All characters should be typed upper case in 10-pitch Pica type, using a standard typeface (no italics or script). Do not put a dollar sign ($) in front of monetary figures. Enter dates in the MM/DD/YY format (ie, 09/24/92).

The shaded areas of the sample form and corresponding items marked below with an asterisk (*) *must* be filled out each time a claim is filed. Do not leave these spaces blank. Other areas of the form should be filled out when there is information pertinent to the claim.

Since the HCFA 1500 form is also used by various government and private health programs, some spaces on this form may need different information for Medicare than it appears to be requesting. Read the following instructions carefully; they pertain only to Medicare claims.

Following is a line-by-line explanation of how to fill out each box:

1* Indicate the type of claim being filed. If this is a Medicare claim, check the Medicare box.

1a* Indicate the patient's Medicare Health Insurance Claim Number (HICN) regardless of whether Medicare is primary or secondary.

2* Indicate the patient's full nan exactly as shown on the p tient's Medicare card.

3* Indicate the patient's date birth and sex.

4 If the patient has Medicare secondary insurance, indica the name of the person with tl primary insurance here. If tl primary insured and the patie are the same, then the wo SAME may be entered.

5* Indicate the patient's perm nent mailing address and tel phone number.

6* Indicate the patient's relatio ship to the insured.

7 If box 4 has been filled ou then this information must l filled out as well. If the insur and the patient are the sam enter SAME.

8* Check the appropriate box for marital and employme status.

9* List the name of the perso with secondary coverage. If it the patient, write SAME. there is none, write N.A.

9a Indicate the policy number the secondary insurance.

9b If the secondary insured polic holder is not the patient, th this information must l specified.

9c Do not enter the employer school name. Instead, indica the claims processing address the secondary insurance.

9d Indicate the name of the Me gap or employer supplement insurance plan.

10 (a,b&c)
Must be filled out. (If you a swer NO to all question Medicare is probably the p mary payer).

10d Medicare uses this space to ide tify all types of coverage, oth

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

APPROVED OMB-0938-0008

Shaded areas must be filled out for *each* Medicare claim. DO NOT PHOTOCOPY THIS PAGE.

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

STATE

8. PATIENT STATUS Single Married Other

CITY

STATE

TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE

TELEPHONE (INCLUDE AREA CODE) ( )

RED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

RED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

RED'S DATE OF BIRTH YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary his claim. I also request payment of government benefits either to myself or to the party who accepts assignment

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

URRENT: YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

EFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

S OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

E(S) OF SERVICE From YY MM DD	To YY MM DD	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

AX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

E OF PHYSICIAN OR SUPPLIER DEGREES OR CREDENTIALS the statements on the reverse bill and are made a part thereof.)

DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN#

GRP#

than Medicare identified in the claim. If the supplementary insurance is Medigap enter MG, if Medicaid enter MDC, if employer supplemental enter SP, if Medicare secondary enter MSP.

11 Indicate the primary insurance policy number. Fill this out only if Medicare is the secondary coverage.

11a If the policyholder is not the patient, then this information must be indicated.

11b If workers' compensation is involved, indicate the name of the patient's employer.

11c Indicate the name of the primary insurance company.

11d* If Medicare is secondary, then check YES. If Medicare is primary, check NO.

12* Authorized representative must sign and date this block unless the signature is on file.

13 Authorizes payment to the physician or supplier.

14 Enter the date of the current illness, injury, or pregnancy.

15 Do not fill this in. Leave blank for Medicare.

16 If workers' compensation is involved, specify dates the patient is unable to work.

17* Fill in the name of the referring physician or your name if no referral was involved.

17a* Indicate the UPIN of the other physician if it is from a referral or ordering physician. If no referral was involved, indicate your own UPIN.

18 Indicate the dates of service in the hospital. This information is not mandatory but gives the carrier a better picture of the total care rendered.

19 This box is for use by other than physician providers, such as physical therapists or podiatrists.

20 Use if billing for a clinical lab test performed outside your office. If you purchased the technical component and are billing this to Medicare, check YES. If you performed the technical and professional components in your office, check NO and use the appropriate modifier.

21* Use the complete ICD-9-CM code. Do not include code narratives.

22 Leave blank. Not required by Medicare.

23 Use the PRO number for assistants at cataract surgery.

24a* Enter month, day, and year for each procedure separately.

24b* Indicate the appropriate two-digit place of service code. Codes are listed in Medicare Newsletter 107. (Contact your carrier for a copy, if needed.)

24c Leave blank. Not required by Medicare.

24d* Use the proper CPT or HCPCS code, up to a maximum of 6, with up to three modifiers.

24e* Indicate the primary diagnosis as 1, 2, 3, or 4. Indicate only the primary diagnosis for the corresponding procedure code in this box.

24f* Enter the charge amount.

24g* Show the days or units.

24h Leave blank. Not required by Medicare.

24i* Check here if the service was performed in an outpatient hospital setting or emergency room.

24j Leave blank. Not required by Medicare.

24k Indicate the carrier-assigned physician identification number for the performing provider if part of a group practice.

25* Indicate the tax identification number.

26 Not required by Medicare, b offices may indicate a phys cian-assigned patient numb for bookkeeping purposes.

27* Indicate whether you accept a signment of Medicare benefits

28* Indicate the total charge for tl services provided.

29* Indicate the amount the patie paid.

30* Show the balance due.

31* Show the physician's or repr sentative's signature.

32 If the physician provided se vices in a place other than tl office, put the name and a dress of the facility here.

33* Indicate the physician's nam address, and telephone numb Also indicate the PIN number in individual practice and GR number if providing services part of a group.

You may purchase the ne HCFA 1500 form from local prin ing vendors or directly fror Superintendent of Documents, U Government Printing Office, Was ington, DC 20402, (202) 783-323 or, American Medical Associatio PO Box 109050, Chicago, Ill 6061 (800) 621-8335.

Forms are not available throu Blue Cross and Blue Shield of Tex or the Texas Medical Association.

If you have questions regardi HCFA 1500 forms or any other a pect of filing a Medicare claim, co tact the Medicare specialists in tl TMA health-care financing depa ment, Bradley Reiner and Pat Coff at (800) 880-1300 or (512) 370-14 or (512) 370-1416, respectively.

nportant dates loom or compliance with CLIA egulations

THE FINAL RULES FOR THE Clinical Laboratories Improvement Amendments of 1988 (CLIA '88) were released in February, and the Texas Medical Association has developed an action plan to help physicians cope with yet another set of federal regulations.

The CLIA rules will go into effect September 1, 1992, and laboratory inspections are expected to begin at the same time.

Congress began its debate over regulating laboratories about 4 years ago amid news stories of abuses and misdiagnoses related to poor regulation of clinical labs. Two years after the law was passed in 1988, the first set of proposed regulations was published by the Health Care Financing Administration, but was met with strong protests from more than 60,000 physicians, who said the rules would hurt their ability to care for patients.

The final rules show a marked improvement over the original ones.

TMA's action plan contains several strategies to help physicians deal with the new CLIA regulations by September 1. These include:

- A series of educational workshops and a publication are under development to guide physicians through the maze of new forms and regulations. Details will be available by early summer.
- Expert technical and legal assistance is available from TMA staff members to assist physicians with problems. Contact Pat Coffey, physician reimbursement specialist, at (800) 880-1300 or (512) 370-1416.
- A campaign to disseminate information about CLIA regulations to physicians is being planned through county medical societies and specialty societies.

"These regulations are just part of a series of new government regulatory hassles that are coming at physicians this year," said David Marcus, PhD, TMA director of health-care financing. "But because of the sanctions doctors may face if they don't meet the deadline to become certified or meet the proficiency testing standards, we strongly encourage them to educate themselves about the CLIA regulations and to comply. And we stand ready to assist them in any way we can."

The CLIA regulations apply to anyone who performs testing of human specimens for the diagnosis, prevention, or treatment of disease, from physicians who perform the most basic tests to those who operate sophisticated office laboratories. The only exemptions are facilities that perform tests for forensic purposes, research laboratories that do not report patient results, and facilities certified to perform only urine drug testing.

The key date for Texas physicians to remember is September 1, 1992. Physicians and laboratories must be registered with the Health Care Financing Administration (HCFA) by that date. HCFA sent out a questionnaire last year to more than 600,000 laboratories, requesting information about testing instruments, methods, menus, and numbers of tests performed, and laboratory personnel training and experience.

Based on that questionnaire, HCFA will send laboratories an application for a registration certificate (a HCFA-109 form) and a bill for the registration fee. Completion of the application and payment of the fee registers the physician under CLIA and brings him or her into compliance with the law. The fee for certification is based on the complexity of tests performed. HCFA has designated three levels of testing: waived, moderate complexity, and high complexity. (See box.)

A physician's office that performs only waived tests is eligible for a waiver certificate. Waived tests are simple, stable, and require a mini-

Test Categories

Waived tests

- Dipstick or tablet reagent urinalysis (includes 10 analytes)
- Fecal occult blood
- Ovulation tests — visual color tests for human luteinizing hormone
- Urine pregnancy tests — visual color comparison tests
- Erythrocyte sedimentation rate — nonautomated
- Hemoglobin, copper sulfate — nonautomated
- Spun microhematocrit
- Blood glucose testing (using monitoring devices FDA cleared for home use)

Moderate complexity tests

Approximately 7,500 tests and analytes (see *Federal Register* for details).

High complexity tests

Most complex tests and analytes, specifically clinical cytogenics, histopathology, histocompatibility, and cytology. Tests not on the HCFA list must be considered high complexity until they are categorized.

mal degree of judgment and interpretation, and include tests cleared by the FDA for home use.

Physicians who did not receive a questionnaire and who believe they should be certified under CLIA should immediately request a registration form. In Texas, contact the Texas Department of Health, Health Facility Licensure and Certification Division, 1100 W 49th St, Austin, TX 78756, or call (512) 834-6650 and request a HCFA-109 form.

HCFA may impose stiff sanctions against a laboratory or physician for failure to comply with the regulations, so physicians who have not heard from HCFA and who believe they should be registered are advised not to wait for HCFA to contact them.

Other key dates relating to CLIA that physicians should keep in mind are that they should enroll for proficiency testing during 1993, they must participate in proficiency testing by January 1, 1994, and sanctions begin for failure to perform proficiency testing by January 1, 1995.

To order a copy of the CLIA regulations, write the Government Printing Office, Attn: New Order, PO Box 371954, Pittsburgh, PA 15250-7954. Request a copy of the February 28 *Federal Register*, stock No. 069-001-00042-4. The cost is $3.50. Make checks payable to Superintendent of Documents. For credit card orders, call (202) 783-3238; for Fax orders, the number is (202) 512-2250.

TMF awarded regional CHAMPUS review contract

THE DEPARTMENT OF Defense has awarded the Texas Medical Foundation (TMF) the 1992 CHAMPUS regional contract for medical peer review, effective May 1, 1992.

Since 1989, TMF has conducted medical peer review of CHAMPUS civilian hospital admissions in Texas. With implementation of the 1992 regional contract, TMF's medical peer review responsibilities will expand to civilian hospital admissions in Arkansas, Kansas, Louisiana, Missouri and Oklahoma. TMF was awarded a 1-year contract with two optional renewal periods.

The CHAMPUS contract incorporates a single records processing center that will coordinate most data processing activities for TMF and other regional review contractors. "On-line" criteria for the use of nonphysician reviewers is also included in the contract. CHAMPUS believes that the use of "on-line" to conduct initial nonphysician screening of medical records will facilitate more consistent review nationwide, according to TMF officials. ★

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Legislative Affairs

Rio Grande Valley physicians call for tort reform

PHYSICIANS IN THE RIO Grande Valley are angry and frustrated about the legal climate in the area. And they let members of the Texas Health Policy Task Force know it when the panel went to McAllen recently.

Backed by hospital administrators and others, the physicians on April 15 urged the task force to recommend meaningful tort reforms that could end the lawsuit abuse they believe is threatening access to health care in the area.

Testifying at one of several regional hearings being conducted by the Health Policy Task Force, Don Warden, MD, Weslaco, called for limiting damages awarded in liability cases to actual economic damages. He also called for a more specific definition of circumstances under which punitive damages can be awarded and for an end to joint and several liability, which allows plaintiffs to go after those with the "deepest pockets."

"The malpractice climate in the Rio Grande Valley makes it extremely difficult to recruit physicians," said Dr Warden, a member of the Texas Medical Association Physician-Patient Advocacy Committee and medical director of the nonprofit Knapp Medical Center. "Some physicians have reported that they are going to leave this year, partly because of the legal climate."

Jerry Behal, MD, McAllen, called the "medical legal crisis" one of the largest obstacles to providing care.

Don Warden, MD, Weslaco, testifie during hearings of the Texas Health Policy Task Force in McAllen.

Physician anger over lawsuit abuse in the Rio Grande Valley peaked last October when Knapp Medical Center was judged liable for the acts of a contracted physician in the center's emergency room and ordered to pay in excess of $10 million. Knapp administrator Robert Vanderveer told the task force the judgment threatened to close the hospital, which would have cost the area 700 jobs and seriously restricted access to care. More than 43% of the hospital's patients in 1991 were Medicaid patients.

Knapp was able to keep its doors open by reaching an out-of-court settlement for $2 million. But even that was a serious strain for the medical center, Mr Vanderveer said.

The testimony of Drs Warden and Behal bolstered arguments for tort reform made to the task force's subcommittee on cost containment in Austin on April 3. At that meeting, David Kittrell, MD, a San Antonio obstetrician/gynecologist and consultant to the TMA Council on Legislation, told the panel the threat of lawsuits is limiting access to care throughout the state, particularly in the areas of obstetrics.

"Probably my specialty has been one of those most affected by the liability system, its costs, and th threat of lawsuits," he said.

Dr Kittrell pointed to 1988 survey of Texas phys cians that showed 37% ha limited or eliminated som procedures because of liabil ty concerns, including 62% of family and general pract tioners and 52% of obstetr cians and gynecologists. He recom mended that the task force study th effects of liability on access to car cost of care, and availability of care

Roger Detrich, a TMA consu tant on professional liability, sai the task force needs to look at re ducing the frequency and severity c malpractice claims, discouragin frivolous suits, establishing alterna tive dispute resolution systems, es tablishing practice parameters, se ting up risk management activitie to prevent and reduce injuries, re quiring certificates of merit for suit to go forward in the courts, limitin noneconomic damages, setting up sliding scale for attorneys' fees, an establishing new ways of providin insurance to physicians.

State Sen Eddie Lucio, Brownsville Democrat who is member of the task force, said h will recommend some tort reform to the Texas Legislature in 199 regardless of the task force recom mendations.

Senator Lucio proposes that th state cap noneconomic damages i civil lawsuits, underwrite liability ir surance for hospitals and doctors and keep between one third and on half of punitive damages awarded i all civil cases to provide health-car

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Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs section of* Texas Medicine.

TMA MEMBER NAMED TO CANCER COUNCIL

TEXAS MEDICAL ASSOCIATION member Courtney Townsend, Jr, MD, Galveston, has been appointed to the Texas Cancer Council.

Dr Townsend is director of the surgical research laboratory at The niversity of Texas Medical Branch at Galveston and interim director of the TMB Cancer Center. He was appointed to a 6-year term on the council by t Gov Bob Bullock.

"Dr Townsend's vast experience in the field of cancer research and his previous ork on committees associated with the Texas Cancer Council make him exceponally well-qualified for this position," Lieutenant Governor Bullock said.

overage for the poor.

"I think tort reform is a major art of the recommendations we eed to come up with for the next gislative session," Senator Lucio iid. "We must take that into conderation if we're going to do someing about keeping the cost of ealth care down in Texas."

At the McAllen hearing, Dr Behal lso urged task force members to ddress urgent public health conerns, such as smoking, alcohol and rug use, and teen pregnancy.

"Texas has more children delivring children than any state in the ation," he said. "This is a shameil failure in our current sex educaon and, therefore, our AIDS eduation, which means we're facing ore problems."

EXPAC scores big wins n primary elections

A HOUSTON ANESTHESIOLOGIST seeking to become the only physician member of the exas Legislature has cleared his rst obstacle.

Kyle Janek, MD, was among nuerous political candidates enorsed by the Texas Medical Assocition Political Action Committee ho won impressive primary or unoff victories for spots on the ovember general election ballot.

Also, all three TEXPAC candiates for the Texas Supreme Court on their races, with Dallas appelate judge Craig Enoch defeating harles Ben Howell for the Republian nomination in Place 1 and incumbent Justice Jack Hightower defeating Paul Banner for the Democratic nomination in Place 3. Judge Enoch will face incumbent Justice Oscar Mauzy in November, while Justice Hightower will be challenged by Democrat John D. Montgomery.

TEXPAC also endorsed Republican incumbent Eugene Cook in Place 2. Justice Cook was unopposed in the primary election but will face Democratic challenger Rose Spector in November.

In other races, TEXPAC-endorsed candidates won nine of 10 contested primary races for the US House of Representatives and five of seven contested races for the Texas Senate. A majority of TEXPAC candidates for the Texas House of Representatives also won their campaigns.

Dr Janek won the Republican nomination in Texas House District 135 defeating fellow Republican Mike Shelby. He will face Democratic incumbent Sue Schecter in the general election.

If Dr Janek wins that race, he will become the only physician in the legislature and the first since former state Rep Mike McKinney, MD, Centerville, retired from the House in 1991.

Dr Janek often is asked why a physician would want to run for political office, but he said the point is that people need to be involved regardless of what they do for a living.

"Right now we've got a legislature that's dominated by one particular profession," he said. "That's not their fault. It may be the fault of the rest of us for not getting involved."

However, Dr Janek said "it doesn't hurt to have a physician in the legislature" with the licensing statutes of physicians and all allied health personnel coming up for sunset review in 1993.

"On top of that, we've got a continuing problem with liability and the need for tort reform in Texas," he said. "And, on top of that, we've got the health-care crisis that's starting to bloom all over the country."

While Dr Janek won his runoff contest against Mr Shelby, Houston chiropractor Ben Beard was defeated in a Democratic runoff for District 145 by TEXPAC-endorsed candidate Diana Davila.

Contributions to Texas Medical Association PAC (TEXPAC), Texas Medical Association PAC-Statewide (TEXPAC-Statewide), and American Medical Association PAC (AMPAC) are not deductible as charitable contributions for federal income tax purposes.

Voluntary political contributions to TEXPAC are shared with AMPAC. Contributions are not limited to the suggested amount. Neither TMA nor AMA will favor or disadvantage anyone based on the amounts or failure to make contributions. Contributions to TEXPAC and AMPAC are subject to Federal Election Commission regulations. Federal election law prohibits TMA from soliciting donations from persons who are not in its solicitable class (eg, TMA members and their families). All donations received from persons who are not in TMA's solicitable class will be returned.

New health reform plan maintains free-market system

A NEW HEALTH-CARE REFORM plan that would build on positive aspects of the current system and maintain the free-market approach has been unveiled by conservative congressional Democrats.

The new plan, announced April 8, is being proposed by the Conservative Democratic Forum and would use managed competition to control costs and provide consumers with better information upon which to base their health-care decisions.

"We feel it is important to let people know there are alternatives to health reform other than those that have been discussed to this point," said Texas Congressman Charles Stenholm, founder of the forum, which includes nearly 60 conservative and moderate Democrats in the US House of Representatives. "Rather than nationalized plans, which destroy our private market system, or 'pay or play' plans that put people out of business, we believe we can retain quality and choice while improving accessibility and affordability."

Under the managed competition proposal, insurance companies, physicians, and hospitals would pool together to form cooperative organizations to offer health insurance and health care as a single product. Those partnerships would have to publicly account for costs and medical outcomes.

Other parts of the plan call for paperwork reduction and administrative simplification by both insurance companies and federal government programs; increased emphasis on preventive care, including immunization of children, prenatal care, and health promotion; tort reform to reduce expensive litigation and the cost of defense medicine; and expansion of Medicaid to cover all those with incomes below 100% of the federal poverty level. The plan also would make health insurance premiums paid by the self-employed 100% tax-deductible.

Tort reform proposals include limiting noneconomic damages, allowing periodic payment of large awards, and reducing unreasonably long statutes of limitations.

Details of the forum's plan are still being developed. The bill was expected to be filed by late spring.

TMA public affairs division staff and the Council on Legislation presently are analyzing the proposals. ★

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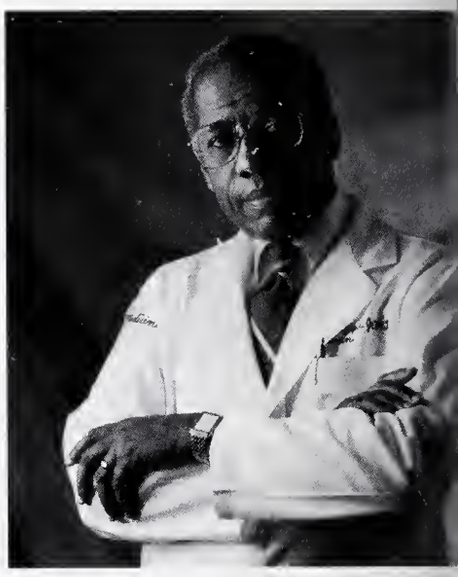

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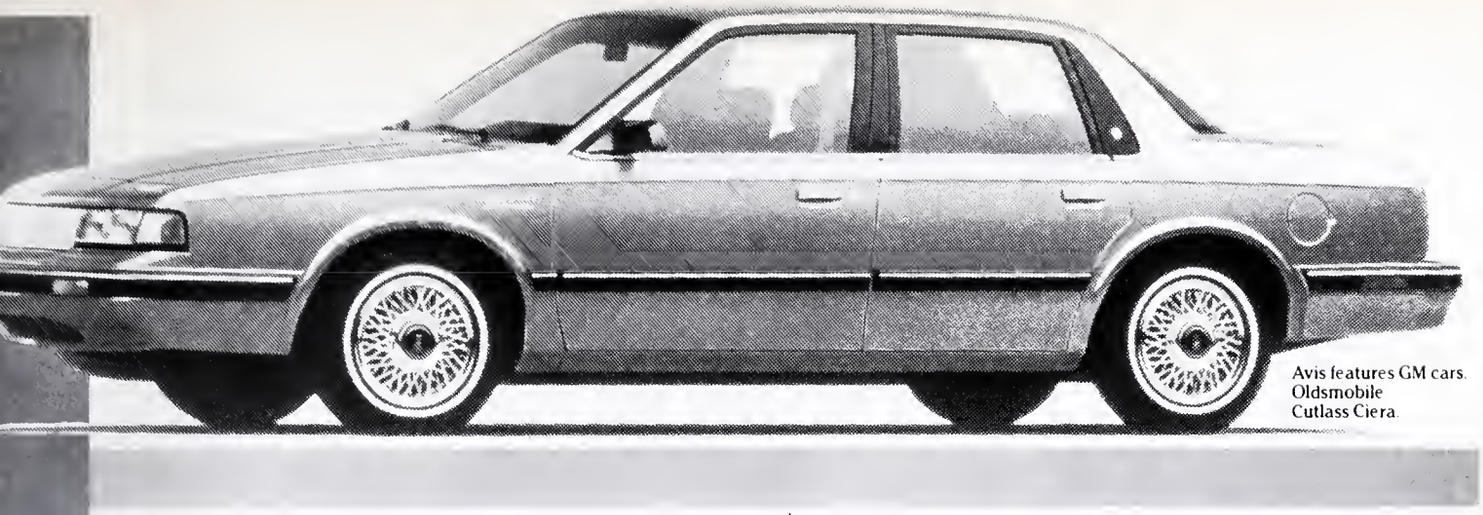

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Science and Education

Student loan program revisions stall in Congress

CONGRESSIONAL ACTION on the Higher Education Reauthorization Act, including a key provision that would end most deferments for student loans, was awaiting action in late April by a House-Senate conference committee.

The Senate Labor Committee approved the Senate version of the bill, which would eliminate student loan deferments as of 1993. Like the House version of the bill, resident physicians are not singled out as a group. In addition, the Senate bill restricts the availability of forbearance to residents whose debt exceeds 20% of their income and limits the maximum forbearance period to 3 years.

Under the current provision of the act, many medical and other students were allowed a 2-year deferment of student loan payment and interest, and forbearance of payments until training was completed. Deferment means that the loan principal does not accrue interest during a specified period; under forbearance, interest accrues. Once their training is completed, physicians must repay their loans within 10 years.

The Senate version of the bill deletes this provision, but the House version contains language that would allow these deferments to be based on a debt-to-income ratio.

TMA President Sam Nixon, MD, Fred Castrow, MD, chairman of the TMA Council on Legislation, and Kim Monday, chairman of the Medical Student Section, sent a letter outlining TMA's position to Rep Craig Washington (D-Houston), a member of the House Education and Labor Committee and a member of the House-Senate conference committee that will resolve the two versions.

The letter stated that TMA prefers the present law, but barring retention of its provisions, supports the House version of the bill. That bill contains provisions for deferment of loans for students while they are still in school, deferment for 2 years for those who are unemployed, and deferment for 3 years for those who are suffering economic hardship.

"We hope that this language (including 2-year deferments) will be retained and that specific living expenses and debts should be considered as factors in determining economic hardship," the letter stated.

The letter pointed out that in 1989 the mean debt of indebted Texas medical school graduates was $35,298, and that in 1990 the average debt per graduating medical student at The University of Texas Medical Branch at Galveston was $38,919, at The University of Texas Health Science Center in San Antonio, $48,247, and at Baylor College of Medicine, $44,089.

It was uncertain in late April when the House-Senate conference committee would meet to discuss the bills. Some sources said it could come as early as late May or June or it could be delayed until late in the session, possibly October or November.

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

Researchers seek new class of AIDS drug

Baylor College of Medicine, Houston — By demonstrating method that blocks production HIV in cells, Baylor researchers the Houston Veterans Affairs Med cal Center hope to develop a ne class of AIDS drug. Investigators d signed short pieces of synthetic si gle-stranded DNA called oligonu cleotides that are able to bind to region of the AIDS virus DNA an form a three-stranded structur called DNA triplex. Formation this triplex was found to interfe with the replication of the virus. R searchers found that when th oligonucleotides bound to contr regions of the HIV DNA, key pr teins necessary for virus replicatio could not attach properly. Scientis say the research could lead to a ne group of AIDS drugs that can sto the replication of HIV in infecte cells at the genetic level.

New substance could solve problem of vessel graft failure

The University of Texas, Austin – Damaged human veins and arteri have been repaired for decades wit synthetic fabrics, but medical r searchers have never solved the prol lem of rejection caused by clotting scarring. A new substance being teste at UT-Austin, however, could "trick blood vessels into accepting foreig material. According to research pr sented to the American Chemical Soc ety in April, the substance is a peptic or synthetic protein fragment that ma someday be attached to graft walls form tiny "hooks" that will attract e dothelial cells. The endothelial cel

cover the synthetic graft and pre-
it unwanted substances from the
od or cell walls from clotting or
cking the vessel. Researchers hope
egin animal testing of the substance
he near future.

Researcher patents formula for blood substitute

*he University of Texas Health Sci-
ence Center, San Antonio* — A re-
rcher here has patented a formula
a new blood substitute that is less
ensive and more effective than
vious substances. The formula,
led Hyperosmolar Oxyreplete
mosubstitute, was developed by
omas Runge, MD, professor of
gery at UTHSC-SA and a professor
biomedical engineering at UT-
stin. Development of the solution
mportant because it could reduce
incidence of brain damage from
n-heart surgery. The proposed
stitute might also help hospitals
d the military meet emergency
ds for blood, reduce the risk of pa-
it infection, and help surgeons pre-
ve donor organs before transplant.

irst Alzheimer's program established for native Americans

*he University of Texas Southwest-
ern Medical School, Dallas* — Re-
rchers here are launching a study
Alzheimer's disease among native
ericans in Oklahoma. Over the
t 2 years, the clinical care pro-
m at Southwestern's Alzheimer's
ease Research Center will open
llite clinics in urban and rural ar-
with large minority populations
northern Oklahoma and northeast
as. The Oklahoma component is
first clinical research program to
k at Alzheimer's disease in the na-
American population, according
to researchers. Research among native Americans will present several challenges, among them the fact that there is no word in the Cherokee language for disease. Also, many older native Americans do not speak English and may only use native American medicine, so they have no conventional medical history. The project is funded by an $800,000 grant from the National Institute on Aging.

Scientists developing brain tissue in laboratory dish

The University of Texas Medical Branch at Galveston — An alternative to using fetal brain tissue to treat brain injuries and disorders is being developed at UTMB. A federal prohibition on the use of fetal tissue for research and drug development has caused medical researchers to seek alternatives. The research, funded by the Moody Foundation and presented to the American Society for Neurochemistry in March, uses a culture of brain cells called HCN-1A, which was developed at Johns Hopkins University from the brain of an 18-month-old girl with unilateral megalencephaly. Researchers confirmed that the cells resemble neurons in important ways. They are primitive brain cells that can be induced to mature by various agents. Scientists see a possible use for the cells in the treatment of Parkinson's or Alzheimer's diseases.

Information for this column comes from a variety of sources, including academic institutions, state and federal agencies, and private institutions. We welcome submission of items of interest. Send them to Texas Medicine, *Science and Education Editor, 401 W 15th St, Austin, TX 78701.*

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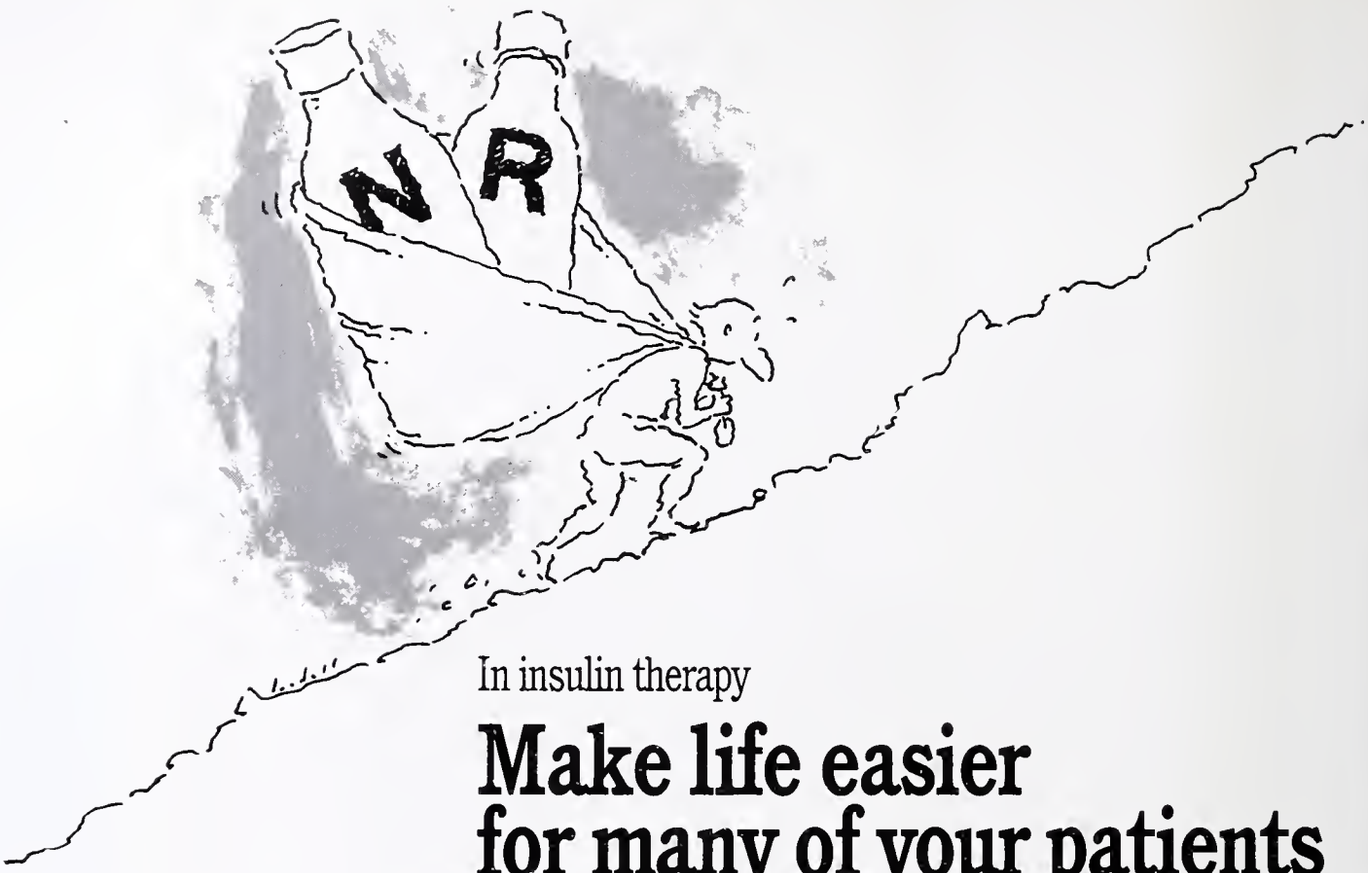

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CASE HISTORY

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CASE SUMMARY

A fifty-year-old woman was seen by her general practitioner for indigestion and intermittent pain in her epigastrium. The doctor obtained an upper GI series revealing a hiatal hernia, which he felt explained her symptoms. Antacids and sleeping in a "propped up" position decreased her symptoms.

After two to three months the pain returned and radiated to her back. She had lost ten pounds which she attributed to dietary intolerance. Her doctor obtained a cholecystogram that revealed gallstones. The patient was then started on anticholinergics which improved her symptoms. She was informed that she would probably require a cholecystectomy.

One month later the patient returned jaundiced and having lost five more pounds. A general surgeon consultant obtained an MRI which revealed a cancer of the pancreas which was found to be inoperable.

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Big $ Money for Big Ideas:

Medical Research in Texas

BY MARK RICHARDSON, ASSOCIATE EDITOR

If excellence in the pursuit of science were the only criterion for being a research physician, there probably would be more of them. But researchers often must divide their time among clinical, administrative, and other duties. They frequently are paid less. Much of their work is tedious and must be painstakingly documented. And sometimes, though not often, weeks, months, and even years of work fail to bring the desired results. There is little glamour.

Consequently, compared to the more than 28,000 licensed physicians practicing in Texas, the number of research physicians is small, perhaps fewer than 3,000.

But one would be hard pressed to find a smaller group of people whose work has a more profound impact on the health of Texans. Or whose work has a bigger impact on the financial health of Texas medical institutions.

Medical research is big business in Texas, putting more than $1 billion each year into the economy. Most of the money that funds research is garnered through competitive grants. Scientists and institutions fight for a larger piece of the funding pie, which threatens to shrink as government funds are diverted to other priorities, and private endowments find it harder to draw contributions as the economy stays mired in recession.

Yet, most people connected with medical research in Texas are highly optimistic about its future. As Texas institutions and scientists receive larger grants and more projects, the state's stature in the national and international research community increases. A healthier and more prosperous Texas stands to be the result.

A primary care physician going through a day of making rounds and seeing patients may write a dozen or more prescriptions, order diagnostic tests, send blood samples to a lab, or refer a patient to a specialist for possible surgery. A specialist might order CT scans, an MRI, or other sophisticated diagnostic procedures. Surgeons routinely use laparoscopic equipment, ventricular assist devices, lasers, and other technological tools.

In today's high-tech medical world, such events are merely routine.

But as they use each drug, each diagnostic procedure, each new piece of medical technology, physicians may not always be aware of its genesis and the role that biomedical and biotechnical research in Texas may have played.

Those physicians in the front lines of medicine, treating patients day in and day out, have a hidden cadre of supporters within the group of major research facilities in Texas and around the country who develop the new weapons to fight the health-care battle.

Medical research expenditures at major medical institutions in Texas, 1990–1991.*

Research Institution	Federal Funds	State Funds	Institution Controlled	Private Funds	Total Fundin
Baylor College of Medicine	$81.7	$3.1	$8.5	$62.0	$155.3
UT Southwestern Medical Center	64.8	14.9	1.1	40.7	121.5
M.D. Anderson Cancer Center	32.3	55.9	15.1	9.3	112.6
UT Health Science Center/San Antonio	39.1	10.5	0.0	12.4	62.0
UT Health Science Center/Houston	32.8	6.5	1.3	13.3	53.9
UT Medical Branch/Galveston	23.8	5.8	2.6	8.7	40.9
Texas Tech Health Sciences Center	3.2	1.6	0.6	1.3	6.7
Texas A&M College of Medicine	2.6	0.2	0.0	0.6	3.4
Texas College of Osteopathic Medicine	2.6	0.1	0.0	1.1	3.8
Totals	**$282.9**	**$98.6**	**$29.2**	**$149.4**	**$560.1**

* In millions

Source: Texas Higher Education Coordinating Board, Baylor College of Medicine

Taking the lead . . .

Medical research in Texas has gained national prominence in recent years, due in part to several institutions taking a lead in research in areas such as breast cancer, AIDS, Alzheimer's, cardiovascular disease, biotechnology, and gene mapping. Dozens of researchers at Texas institutions rank among the top echelon in the nation and the world in their fields.

So while the total amount of medical research in Texas lags behind that in some other states, particularly those on the West and East Coasts, Texas' stature among members of the research community is growing, along with the financial commitment from federal and state governments and from private sources such as foundations and corporations.

John Howe III, MD, president of the Texas Society for Biomedical Research, says the state is well-positioned to take a stronger leadership role in medical research.

"Over the years, Texans within the Capitol and within organized medicine have worked hard to develop precious assets in the biosciences," he says. "Some of the examples abound in the Texas Medical Center in Houston, the Southwestern Medical Complex in Dallas, the South Texas Medical Center in San Antonio, as well as other cities such as Galveston, College Station, and Lubbock."

Dr Howe, who is also president of The University of Texas Health Science Center at San Antonio, says the challenge is to build from a solid foundation.

"Today, we're seeing the fruits of our advocacy in the form of superb health institutions devoted to teaching, patient care, and research," he says. "The question of the day is: Can we build upon these precious assets, leverage them, and further increase the prominence of Texas in the world of medicine? And I believe the answer is an unequivocal yes."

It's money that matters . . .

In the early days of the space program, or so the story goes, a conversation took place between aviation pioneer Chuck Yeager and a NASA official about what made Yeager's experimental jet airplane fly.

The young and brash Yeager was eager to explain the laws of physics, aerodynamics, lift and drag, but th NASA official interrupted him.

"It's money, son," he said. "Thos planes don't leave the ground witl out someone paying for it."

And so it is with biomedical an biotechnical research. None of gets off the ground without mone and lots of it.

While it is difficult to get a clea picture of just how much money takes to run Texas' research facilitie and programs, many agree that be tween $500 million to $800 millio is a reasonable estimate. The nin major Texas research institution spent about $560 million on medica research in 1991. Using standard U Department of Commerce measure that research spending contributed total of more than $1.1 billion in to tal impact to the state's economy.

The Texas Higher Education Co ordinating Board, which tracks onl state-supported institutions, note that during 1990–1991, Texas pub lic institutions spent just under $45 million for medical, biological, an other life science research.

The state-run medical institution are Texas A&M University Colleg of Medicine; The University of Texa System's institutions, including M.D Anderson Cancer Center, UT Medi cal Branch in Galveston, UT Healtl Science Centers in Houston, San An tonio, and Tyler, and UT Southwest ern Medical Center at Dallas; Texa Tech University Health Sciences Cen

ers in Lubbock and El Paso; and the Texas College of Osteopathic Medicine in Fort Worth.

Of the just under $1 billion spent n all types of research by state-supported institutions, medical and biological science make up the lion's are, accounting for 47% of the total.

And that is only for state schools. aylor College of Medicine in Houston, a private school that does obain large portions of its funding om state and federal government ources, consistently ranks first in exas in research funding, with a total of $152.2 million in total research support for 1992.

There are also numerous hospials, clinics, pharmaceutical companies, private foundations, and priate corporations conducting iomedical and biotechnical research around the state. While it is ifficult, if not impossible, to quanty the funding levels of private research, experts estimate that these rograms add another $150 to $200 illion to the total.

According to the Texas Higher ducation Coordinating Board, caner research is the highest funded tem among all research in Texas, vith a total $133 million from all ources. Biotechnology is No. 2 at 53 million. The only other medical esearch in the Top 10 is AIDS research, with just over $7 million.

t doesn't grow on trees. . . Most of he funding for medical research in exas comes from the federal government. In 1991, The National Intitutes of Health (NIH) awarded 297 million in grants to medical research programs in Texas.

Federal funds account for 50.5% f the $560 million spent on medical esearch by major medical institutions in Texas. State funding accounted for another 17.6%, institution-controlled funds made up 7.1%, nd private funding was 26.7%.

The majority of medical research unds from the federal government s handled by the NIH, a branch of he US Department of Health and Human Services (HHS), which is the largest agency in the federal government. Other agencies such as the National Science Foundation, the Department of Defense, NASA, and the Department of Energy also contribute to medical research, but NIH will contribute more than $9.4 billion in 1993 towards 22,132 research project grants nationwide.

The nine major Texas research institutions spent about $560 million on medical research in 1991.

The bulk of medical research funds goes to institutions on the East and West Coasts, with California getting the largest cut (more than $835 million), followed by New York with $672 million and Massachusetts with $633 million. Texas ranks fifth among the 50 states in NIH funding, behind California, New York, Massachusetts, and Pennsylvania.

Perrie Adams, PhD, an associate dean at Southwestern Medical School in Dallas, whose primary job is to obtain funding, says the competitive nature of grantsmanship makes it imperative that institutions be prepared to compete for every penny.

"What is really happening is that while there are approximately 125 medical schools in the country, it probably gets down to somewhere in the range of 25 to 30 centers of excellence among those medical schools. And that's where most of that money is going to go," he says. "The review process is such that people look at grants and at where the work is being done and they want to get the biggest bang for their buck."

Dr Adams says that it's difficult to buck the trend of the haves — the Harvards and Yales and Stanfords — continuing to get more grants than the have-nots.

High profile results . . . While getting your hands on research money is important, what you do with it is critical. Texas researchers have put their programs into the national spotlight through aggressive research that has generated major breakthroughs.

State-supported facilities in Texas have a major advantage over their sister institutions in other states — the Permanent University Fund (PUF). The PUF is a $3.5 billion fund dedicated to building facilities for colleges and universities in The University of Texas and Texas A&M University systems. (Texas Tech is the only state medical school without PUF funding.)

The PUF, which derives its funds primarily from oil royalties and grazing rights on 2.1 million acres of land spread across 19 west Texas counties, is second only to Harvard University's $4.7 billion endowment.

The existence of the PUF means that grant funds that go to those schools are spent on research, not to build the facilities in which to conduct the research.

Private schools are often saddled with not only attracting grant funds for research, but with soliciting funds for endowments to build buildings as well.

Texas institutions do this very well. For instance, Baylor College of Medicine announced earlier this year that its New Century Campaign had reached $150 million of its $175 million goal. The fund is primarily designed to build and maintain facilities at the college, though officials say some of it is designated for research.

Where the action is . . . Here is a look at the major research projects under way at medical research institutions in Texas:

Baylor College of Medicine

Baylor weighs in with one of the largest programs in the state, the PUF notwithstanding. Its total research support for 1992 is $152.2

Getting sick for fun and profit

If you have anxiety, psoriasis, hair loss, high blood pressure, athlete's foot, hay fever, gout, asthma, or even a sprained ankle, you may not consider it your lucky day. But some folks in the Austin area have been observed to be quite happy about coming down with some of these ills.

You might be too, if someone were willing to pay you for your trouble.

Austin has become the state's center for private drug testing research, with two major companies, Pharmaco and HealthQuest Research (along with some clinics and other small firms) setting up shop in the last few years. The firms recruit volunteers to participate in studies designed to get new drugs and biological or medical devices through the regulatory and research steps for FDA approval and on to the market.

There is no shortage of people willing to be human guinea pigs for various stages of clinical drug trials when test subjects are paid anywhere from $50 to $3,000 and up. And they needn't have a specified illness; many of the studies require fully healthy individuals as controls. The volunteers may be seen on an outpatient basis for some of the more simple tests, but many studies require a stay in the companies' dormitory facilities for control and observation for as long as 2 months.

According to Pharmaco officials, their company provides consultation, management, coordination, patient evaluation, and the analysis necessary to "move a product from first introduction into man to market acceptance." Pharmaco also has branches in Princeton, NJ, and four European offices.

The main reason for locating in the Austin area, the firms say, is the presence of about 90,000 students at area colleges and universities, such as The University of Texas, Austin Community College, and several others in the area. Since volunteers for the studies must be in good health (with the exception of a required disease or condition) and within 10% to 15% of ideal body weight, students tend to make the best subjects. They also often have a lot of time on their hands for some of the longer term studies that require several weekends or longer stays in the facility. And what student doesn't need the extra money?

So the next time you have an itch, an ache, a sniffle, or a sprain, you might consider a quick trip to Austin for a little medication and some cold cash.

After all, why should little white mice have all the fun?

million, ranking it first in medical research and third overall, behind A&M and UT-Austin.

Baylor has several major research projects that are national in scope and prominence:

- The Human Genome Project, a long-term program designed to completely map the human gene. Baylor researchers have been involved in locating the gene that causes Fragile X Syndrome, a form of mental retardation, and the gene that causes myotonic muscular dystrophy.
- An AIDS Research Center, which pulls together a variety of research projects, including drug therapies, studies on HIV-positive infants, and research on ways to counteract the virus.
- The Alzheimer's Research Center is involved in developing drug therapies to counteract the debilitating disease.
- The DeBakey Heart Center researches diseases such as arteriosclerosis, the causes of heart failure, and inflammation of heart cells after a heart attack, and several other major programs.

M.D. Anderson Cancer Center

M.D. Anderson, a part of The University of Texas System, has research programs valued at more than $90 million a year. The center considers its cancer research program one of the most productive targeted research efforts in the world. M.D. Anderson ranks 45th nationwide and third in Texas in terms of annual awards from the NIH.

M.D. Anderson research projects include basic science research, cancer prevention and control, clinical research, cancer treatment, psychosocial and survivor issues, and public policy issues.

Some of its more notable ongoing projects include:

- The ambulatory treatment center, the nation's largest outpatient chemotherapy unit, which handles about 100,000 patient visits a year. The facility allows many patients to avoid or reduce more costly hospital care.
- The protected environment unit, a 20-bed facility that is the only one of its kind, where patients vulnerable to life-threatening infections spend up to 8 weeks in complete isolation.
- The Science Park research division, located at a wooded Central Texas site, conducts carcinogenesis studies on primates. Recent research at this facility shows that glucarate, a compound isolated from cruciferous vegetables, may help prevent breast cancer. Other studies involve the development of other natural and synthetic substances to inhibit cancer growth.

The University of Texas Southwestern Medical Center

Southwestern Medical Center joined The University of Texas System in 1949, grew quietly in the 1950s and 60s, then rapidly in the 70s and 80s. Today, its research faculty draws more than $70 million a year in grants and is ranked among the top facilities in the country in several areas of research.

Among its major programs are:

- The Gifford Laboratory for Diabetes Research, where researchers recently announced a major step towards the creation of a genetically engineered "artificial beta cell," a potential alternative to human islet-cell transplantation.
- An Alzheimer's and Related Diseases Clinic, which is studying

the disease through postmortem evaluation of brain tissue from both patients' and healthy individuals' brain tissue. The clinic also is working to develop drug therapies for the disease.

- A high-risk pregnancy study designed to identify women with potential pregnancy risks and increase the survival rate among both mothers and children in pregnancies involving hypertension, diabetes, multiple fetuses, and others.
- Development of a "gene gun" to inject DNA into the body, and the study of "DNA immunizations," through which the body's immune system can be stimulated to mount a response to an existing cancer.

In addition, Southwestern has ngoing programs in cancer reearch, hypertension, neurologic diases, and cardiovascular diseases, mong many others.

he University of Texas Health cience Center at San Antonio

Vith a $45 million research budget, ne UT Health Science Center in San ntonio is expanding its capabilities apidly. The center recently opened new $40 million research facility vith a state-of-the-art imaging cener and has several prominent reearch programs:

- AIDS research, with education, prevention, and treatment being studied in more than a dozen programs, including infection control in dentistry and medicine, pediatric AIDS, clinical trials for new drug therapies, and intervention and education of IV drug users.
- Arterial disease research, in which the Palmaz stent was recently developed for holding open iliac arteries and is under study for other placements.
- Cancer research, particularly in the areas of breast cancer, new anticancer drugs, improved drug-delivery systems, and clinical drug testing. Major projects include use of a supercomputer to simulate drug chemistry and design new drugs, the isolation of the human cancer gene related to retinoblastoma, and an NIH program-project on therapeutic research into breast cancers.

Texas ranks fifth among the 50 states in NIH funding.

The University of Texas Medical Branch at Galveston

Medical research at UTMB covers a broad range of topics that school officials say often have immediate application to patient care. The institution spent about $40 million in 1991 in federal and private funding for research. Among its major research programs are:

- The Center for Molecular Science, with studies involving mammalian DNA synthesis enzymes, growth factors for human cells, and others.
- The Center for Wound Healing, which is studying ways to improve and accelerate the healing process by speeding and otherwise affecting cell replication and tissue regeneration.
- The Center for Tropical Medicine, which studies diseases including malaria, cholera, AIDS, and Chagas' disease.
- The Center for Environmental Toxicology, where studies are examining the biomedical effect of discharge of pollutants into the air and water.
- The Center for Biomedical Engineering, in which scientists are designing equipment and techniques for medical diagnosis. Some of the projects include body scanning and tomography, artificial heart valves and laser surgery, and laser optics and noninvasive ultrasonic surgical techniques.

The University of Texas Health Science Center at Houston

UT-Med spent about $29 million on research in 1990. The school's research programs have consistently ranked among the national leaders in the percentage increase in federal funding over 6-year periods, showing most recently an increase of 145% between 1983 and 1990. Its major research areas are basic sciences, pediatrics, the heart, the brain, vascular diseases, and AIDS. Among its chief projects are:

- Reproductive studies testing a solution to prevent pelvic adhesions from forming or reforming after surgery; a nose spray for women who develop fibroids and develop anemia from excessive bleeding; and clinical trials of a drug to treat dysmenorrhea.
- Creation and testing of inexpensive blood substitutes, focusing on a model using a rabbit in which 50% of the blood volume is replaced with the substitute, then oxygen and energy levels are measured to check its effectiveness.
- Development of a ventricular assist device (VAD) for high-risk cardiovascular bypass patients.
- Participation in a nine-center study of the use of tissue plasminogen activator (tPA) as a treatment for stroke victims.

Texas A&M University College of Medicine

TAMU College of Medicine is the state's newest medical school, and by design, its smallest, admitting just 50 students per year, who attend 2 years in College Station, and then do junior and senior clinicals at its campus in Temple. Its research expenditures for 1991 were only $3.4 million, but if it is anything like its sponsoring institution, Texas A&M University, that should grow rapidly. A&M consistently ranks first in Texas in garnering overall research funding, spending almost a quarter of a billion dollars in 1991. The College of Medicine's current research programs include:

- The Institute of Ocular Pharmacology, with major projects in glaucoma treatment and several clinical trials on new medicines.
- The Microcirculation Research

Institute, with projects in microscopic blood vessels, the extracellular matrix, and lymphatics.

- A psychiatry and behavioral medicine study is investigating suicide prevention in the 18–24 age group.

Texas Tech University Health Sciences Center

With a research budget of just over $6.5 million, Texas Tech nonetheless is known for several of its research programs, most notably its program focusing on trauma care and research into adult respiratory distress syndrome. Other areas of research expertise include the neurology of aging, nephrology, reproductive biology, blood substitutes, chronic pain, and telemedicine.

Texas College of Osteopathic Medicine

With a current budget of $3.9 million, TCOM has 71 funded research projects in the areas of nutrition, human genetics, cell biology, and neurobiology. The college has more than 12,500 square feet of space devoted to the care and study of laboratory animals.

Other institutions

Another prominent medical research institution in Texas is the Southwest Foundation for Biomedical Research in San Antonio, where studies are under way on AIDS, cancer, cardiovascular disease, genetic disorders, viral diseases, immunology, and others. The foundation recently celebrated its 25th anniversary.

Research also is conducted at many of Texas' major hospitals. One example is Methodist Medical Center in Dallas, where major research programs center on transplantation of heart, kidney, and pancreas, the development of antirejection drugs, and the diagnosis and treatment of organ rejection.

So-called "performance based funding" could drastically alter the way research is funded by the state.

The future of research . . .

As robust as medical research is in Texas, there are some clouds on the horizon. The mood of the electorate and the legislature is to cut budgets, not enhance them. So-called "performance based funding" (see story, opposite page) could drastically alter the way research is funded by the state. And while federal dollars for research currently are plentiful, a restructuring of the NIH and political fervor to reduce the massive national debt could cut into that source.

At a symposium in San Antonio in February sponsored by the Southwest Foundation for Biomedical Research (SFBR), many of the state's and nation's most prominent researchers gathered for a conference titled, "Today's Opportunities, Tomorrow's Health: The Future of Biomedical Research in America."

While the scope of the conference was national, the fact that it was held in Texas is noteworthy. It points up the leading role the state plays in biomedical research, according to Duncan Wimpress, PhD, the president of SFBR. Much of the symposium was directed at developing a strategic plan for the NIH and research funding, but a lot of discussion centered on the future and direction of biomedical research.

"The lessons of history are crystal clear," said Arthur Kornberg, MD, professor emeritus of Stanford University School of Medicine. "It is crucial for a society or culture to understand the nature of the creative process and to provide generously for its support. No matter how counterintuitive it may seem, basic research is the lifeline of practical advances in medicine; pioneering inventions are the source of industrial strength."

Panels at the symposium discussed critical technologies, research capacities, intellectual capital, stewardship of public resources, and the public trust. Among the recommendations made were the development of an NIH strategic plan, programs to attract more young people into careers in life science and medicine, and increased funding for the NIH, which in terms of purchasing power is the same in 1992 as it was in 1968.

In remarks to the gathered scientists, James O. Mason, MD, PhD assistant secretary of health for HHS, echoed the sentiment that the future of research must be handled with vision and care.

"The US is currently preeminent in biotechnology. But the field is moving rapidly and the historical leadership does not ensure continued superiority," he said. "That's why (the government) has placed so high a priority on making sure this great enterprise we call biomedical research remains in high gear.

"Twenty years ago the word 'biotechnology' didn't even appear in desktop dictionaries," he said. Now, experts predict "the collective industrial impact of biotechnology will exceed the size of the electronics industry soon after we enter the 21st century."

Dr Howe of the Texas Society for Biomedical Research agrees and says Texans must work together to maintain and increase their share of the biomedical research pie.

"Health research is a top priority item for the American public," he said. "These research monies are awarded on a competitive basis. And the fortunes of Texas research institutions are intimately wedded to our success in capturing our fair share of these research funds. As these monies come into Texas, the result is not only idea creations but job creations as well.

"From the laboratory bench to the patient's bedside, (biomedical research) can have a direct impact on the life and health of the Texas economy and all Texans." ★

Medical research funding faces changes at federal, state level

Funding for medical research has shown a steady pattern of growth during the last three decades, with grant awards from the National Institutes of Health growing from $1.1 billion in 1965 to almost $9.4 billion allocated for 1993. Funding at the state level, administered through the Texas Higher Education Coordinating Board, also has grown steadily since a program of competitive, peer-reviewed grants was established in 1985.

But both the federal and the state government are dealing with financial hard times, brought on by a recession and an electorate weary of increased taxation. With more than 50% of all medical research grant monies coming from either federal or state sources, possible changes on the horizon could alter the formula for research funding.

The NIH currently is examining its 50-year-old system of awarding research grants, while the budget writers for the State of Texas are taking a hard look at programs with an eye on making cuts where possible.

While no one is quite certain what these changes will bring to the medical research community in Texas and elsewhere, there is much sentiment that new ideas are needed.

How to get there . . .

"These are changing times," said Louis W. Sullivan, MD, secretary of the US Department of Health and Human Services, "times when government and the academic, professional, and business communities need to think about what we are doing and not doing, and how we can do it more efficiently and effectively. Those of us in biomedical science and technology, in particular, need to reflect on where we are, where we should be, and how best to get there."

The NIH, a division of HHS, currently is studying implementation of a "strategic plan" for biomedical research that may have far-reaching implications for grants. The plan, which was discussed at several symposiums around the country earlier this year, is expected out later this summer.

At the state level, the latest buzzword is "performance based funding," a relatively new concept by which funding for agencies and programs is based on a predetermined set of performance criteria requiring institutions to meet standards in order to retain or increase their budgets in subsequent years.

According to Andrea Cowan, a performance review analyst for the Texas Performance Review, the concept has been tried in some city and county governments, but there is not yet a good model for state government.

"Currently, we budget by program and activity line item," she said. "There is no achievement or performance tied to those line items. The new process that the state is going to is that we will budget by strategies and objectives, and with those will be a performance measurement tied to that strategy by which one can measure the success of that program."

Funding will then be based on how well that strategy performs, she said.

John Howe III, MD, president of the Texas Society for Biomedical Research and The University of Texas Health Science Center at San Antonio, said the concept could ultimately be good for medical research.

"With respect to performance based funding, the intent is both timely and noble. Our legislative colleagues are looking for ways to encourage the best of medicine. And as that encouragement is provided, the Texas health institutions will do well," he said. "At the same time, it's so important that this concern for performance include all of the tasks of our health institutions including teaching, patient care, and research."

Perrie Adams, PhD, assistant dean at The University of Texas Southwestern Medical School in Dallas, said some institutions are concerned about how the funding concept will affect them.

"It definitely could affect research in the sense that academic programs, for example, are based on the number of students and the number of students that graduate, etc, and thus more attention would be paid to how the faculties spend their time relative to that performance measure," he said. "If that is the case, then it may begin to compete with time for research, time to do clinical research, a wide range of indirect hits on both basic research and clinical research. Right now I think it's too early to tell."

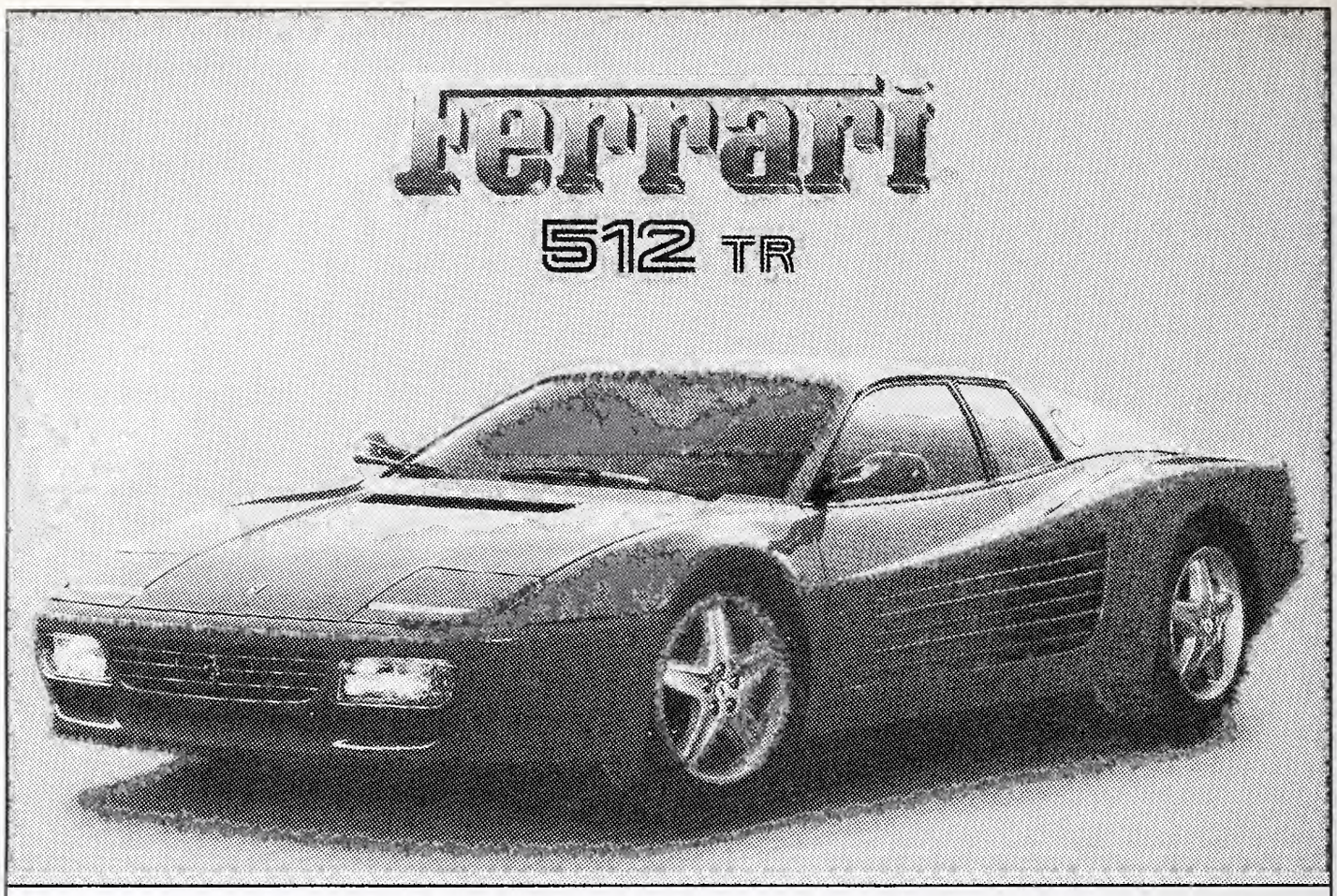
Ahead of the game . . .

Ms Cowan said that medical research, due to the competitive nature of the grant process, may be ahead of the game.

"The research programs probably already have better plans than most of state government because they have to work to get federal grants and convince the state that they deserve state dollars. So they have already developed a stated goal for their research, and that puts them ahead of most state programs," she said.

"It is going to be very important that medical schools and universities really think hard about what their objectives and goals are, and set realistic targets and expectations."

A task force chaired by Kern Wildenthal, MD, PhD, president of UT Southwestern Medical Center at Dallas, is assisting the state in determining the tentative performance funding standards for education. The final report is scheduled to be out by October.



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Law

Training employees required under OSHA regulations

The second part of Texas Medicine*'s series on the new OSHA bloodborne pathogens standard focuses on training and recordkeeping requirements that go into effect June 4, 1992.* Texas Medicine *contacted Jane Matheson, JD, a partner with the law firm of Hughes & Luce in Austin and a former deputy assistant secretary of labor for OSHA, to obtain further information about the nature of the training and recordkeeping requirements and the manner in which these requirements should be implemented. Kathryn A. Christmann, JD, also with Hughes & Luce, provided research for this article.*

THE OSHA BLOODBORNE pathogens standard requires an employer to train all employees with occupational exposure to bloodborne pathogens about the hazards associated with blood and other potentially infectious materials and the protective measures to minimize the risk of occupational exposure. An employer is also required to maintain records related to bloodborne pathogens, including exposure incidents, postexposure follow-up, hepatitis B vaccination status, and training for all employees with occupational exposure.

Physician/employers inadvertently may be vulnerable to citations for recordkeeping violations, says Jane Matheson, JD.

"Some physician/employers are already subject to certain OSHA recordkeeping regulations," she says. "Specifically, any physician/employer with 11 or more employees is required to maintain a log and summary of all recordable occupational injuries and illnesses for his or her place of business. This summary is commonly referred to as an OSHA 200 log.

"During the past several years, OSHA has focused greater enforcement efforts on obtaining compliance with recordkeeping obligations and has issued some very significant proposed penalties for recordkeeping violations. While monitoring recordkeeping compliance in the health services field was not common in the past, with the promulgation of the final standard on bloodborne pathogens, all required recordkeeping obligations will most likely become the target of greater scrutiny. In the event of an OSHA inspection, physician/employers should be prepared to provide the required OSHA 200 logs as well as records relating to bloodborne pathogens," says Ms Matheson.

Effective training is critical

Effective training is a critical element of an employer's exposure control plan. Proper training will help reduce the risk of occupational exposure, thereby reducing exposure-related infection, illness, and death.

Every employee should leave a training session with a basic understanding of the following items:

1. the hazards associated with bloodborne pathogens, particularly human immunodeficiency virus (HIV) and hepatitis B virus (HBV);
2. the modes of transmission and the symptoms of HIV and HBV;
3. the employer's exposure control plan;
4. the use of engineering controls, such as self-sheathing needles;
5. the use of work controls, such a the proper disposal of contam nated needles and other sharps;
6. the proper use of personal protec tive clothing, such as gloves an face shields;
7. the appropriate actions to be tak en in the event of an emergenc involving exposure to blood an other potentially infectious mate rial; and
8. the reasons to participate in th hepatitis B vaccination progran and in postexposure evaluatio and follow-up.

The purpose behind these require ments is to ensure that employees ar aware of the dangers associated wit bloodborne diseases and the need t observe precautions. Employees mus also be able to recognize symptom so that they will be able to seek med ical treatment in the event such treat ment becomes necessary.

Training for all employees

A covered physician/employer mus provide training to all employee with occupational exposure t bloodborne pathogens regardless o their professional education or othe credentials. Therefore, nurses and physicians are required to participate in the training program to the same extent as housekeeping personnel with occupational exposure. The standard, however, does allow the employer some flexibility in tailoring the program to the employee's background and responsibilities.

June 4 deadline for training

A physician/employer must provide free training by June 4, 1992, to all current employees with occupational exposure.

Training also must be provided at

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

ıe time of initial employment for nployees with occupational expo- ıre and when there is a change in ı employee's responsibilities, pro- ɜdures, or work situation that ould affect such employee's occu- ational exposure. The standard oes contain a limited exception for nployees who have received train- ıg on bloodborne pathogens in the ɜar preceding the effective date of ıe standard. These employees, owever, will still need to receive aining with respect to those provi- ons of the standard that were not ıcluded in their original training.

Finally, the standard requires a hysician/employer to provide addi- onal training annually in order to ɜinforce the initial training and to rovide an opportunity for the em- loyer to present new information ıat was not available at the em- loyee's initial training.

All training must be conducted uring working hours at no cost to nployees and at a reasonable loca- on. It is customary for the US De- artment of Labor to take the posi- on that an employer must pay nployees for time spent in training.

eeting the standard training quirements

ı its explanation of the training pro- ısions, OSHA has stated that the training information presented must e understood by the employee; oth- rwise the training will not be effec- ve" (56 Fed Reg 64166 [Dec 6, 991]). Consequently, the standard ɜflects OSHA's emphasis on compre- ension by requiring all training in- ɔrmation to be provided in a man- er appropriate in content and ocabulary to the educational, litera- y, and language background of the mployees in the training session. Vhile OSHA has not expressly mandated that employers be able to document employee comprehension of training, the OSHA compliance directive instructs compliance officers to interview employees to determine that the training was appropriate.

To demonstrate good faith compliance efforts, physician/employers may want to document that question and answer opportunities occurred. Physician/employers may also want to consider holding multiple training sessions, depending upon the cultural and educational diversity of their employees. However, if any physician/employer elects to supplement the required training through the use of written examinations, care should be taken to avoid testing devices that inadvertently result in an adverse impact on members of a class protected by virtue of race, sex, and national origin.

All training must be conducted during working hours at no cost to employees and at a reasonable location.

The training program must address the needs of the particular employees being trained, including focusing on the specific responsibilities of each employee in the training program and how he or she may be occupationally exposed to bloodborne pathogens. Employees must also be able to recognize when they are at risk of exposure to blood and other infectious materials. Additionally, the person conducting the training must be knowledgeable about the subject matter of the training program as it relates to the employee's workplace.

Employees must also be given the opportunity to clarify any concerns regarding occupational exposure. The standard thus requires the training session to provide employees with the opportunity for interactive questions and answers with the person conducting the training session. Both the standard's preamble and OSHA's compliance directive caution that audiovisual presentations and commercial workbooks may not be substituted for the presence of a qualified trainer, although they may be used to supplement the presentation. Likewise, informal discussions are insufficient to satisfy the training requirements of the standard; a more formal program is required.

Obligations involving recordkeeping

In addition to standards such as the one requiring the OSHA 200 log, the bloodborne pathogens standard requires a physician/employer to maintain medical and training records for each employee with occupational exposure. OSHA says these records are necessary to assure that employees receive appropriate information on hazards and effective prevention and treatment measures as well as to aid in developing data on the causes of occupational illnesses and injuries involving bloodborne pathogens.

An employee's medical records will include the employee's name and social security number, a copy of the employee's hepatitis B vaccination status, a copy of all results of examinations, medical testing, and follow-up procedures related to postexposure evaluation, the employer's copy of the health-care professional's written opinion, and a copy of all information required to be provided to the health-care professional treating the employee. Although it is the

physician/employer's duty to create and maintain an employee's medical records, the actual records may be kept in the office of a physician (other than the physician/employer) or other health-care professional who is responsible for treating the employees. Moreover, an employee's medical records do not need to be stored in a separate file as long as the existing file is kept confidential.

Once an obligation arises to create and maintain medical records, a physician/employer should also be aware of obligations under the access to medical records standards 1910.20 of Title 29 of the Code of Federal Regulations. This standard requires an employer to provide periodic notices to employees, advising them of the existence of covered records and the means and methods of securing access to such records.

A physician/employer is also required to maintain training records that show the dates of training sessions, the contents or summary of the sessions, the names and qualifications of the persons conducting the sessions, and the names and job titles of all persons attending the sessions. These requirements are meant to assist the employer and OSHA in determining whether the training program adequately addresses the risks involved in each job and whether each employee with occupational exposure has received the proper level of training.

Access to medical and training records

A physician/employer is responsible for ensuring that an employee's medical records are kept confidential and that they are not disclosed or reported to any person without the employee's express written consent, except as required by the standard or by applicable law. In this regard, the standard provides that an employee's medical

OSHA UPDATE

Here are answers to some of the questions physicians have asked Texa Medical Association about OSHA's bloodborne pathogens standard.

How can I find out if my office meets OSHA standards?

The Texas Workers' Compensation Commission (TWCC) will assist phys cians in determining if they are in compliance with OSHA regulations, whic includes the bloodborne pathogens standard. Under OSHCON, a consultar will inspect your office for violations you might be cited for during an OSH inspection. The TWCC consultant will also review programs and records. written report will be provided and a 1-year exemption from a schedule OSHA inspection will be granted if the office passes the inspection. For mor information or to schedule a visitation, call (512) 440-3708.

What deadlines are on the horizon?

All training and recordkeeping must be completed on or before June 4.

July 6 is the deadline for hepatitis B vaccination and postexposure evalua tion. Information to be given on the hepatitis B vaccine includes its efficac safety, method of administration, and the benefits of being vaccinated. Th vaccine and vaccination must be offered free of charge. The vaccination mus be offered within 10 working days of a new employee's initial assignment. an employee refuses to be vaccinated, the employer must obtain a signed in formed refusal form that states the following:

I understand that due to my occupational exposure to blood or other po tentially infectious materials I may be at risk of acquiring hepatitis B viru (HBV) infection. I have been given the opportunity to be vaccinated wit hepatitis B vaccine, at no charge to myself. However, I decline hepatitis vaccination at this time. I understand that by declining this vaccine, I con tinue to be at risk of acquiring hepatitis B, a serious disease. If in the fu ture I continue to have occupational exposure to blood or other poten tially infectious materials and I want to be vaccinated with hepatitis vaccine, I can receive the vaccination series at no charge to me.

Where can I get written information about OSHA compliance?

An OSHA Compliance Training Manual is now available from Texas Medica Association practice management department. Written and developed by 3C Complete Compliance Corporation, the manual provides complete informatio to assist physicians' offices in complying with the bloodborne pathogens stan dard. Cost to TMA members if ordered before July 1 is $59 plus $6 shippin and handling. The cost after July 1 is $120 plus $6 shipping and handling. T order, call (800) 880-1300 ext 1411 or (512) 370-1411.

What happened with TMA's request for a delay in implementation?

TMA's March 5 request for a delay in the implementation of the bloodborn pathogens standard was denied by the US Department of Labor.

How do I get in contact with OSHA?

Information concerning the bloodborne pathogens standard can be obtaine from one of the following US Department of Labor OSHA area offices:

Austin — Grant Building, 611 E 6th St, Suite 303, Austin 78701, (512) 482-5783.

Corpus Christi — Government Plaza, 400 Mann St, Suite 300, Corpus Christi 78401, (512) 888-3257.

Dallas — 8344 E R.L. Thornton Freeway, Suite 420, Dallas 75228, (214) 320-2400 and (800) 388-3202

El Paso — 5800 Trowbridge, Suite 303, El Paso 79925, (915) 772-9946.

Ft Worth — North Star II, 8713 Airport Freeway, Suite 430, Ft Worth 76180-7604, (817) 885-7025.

Houston (North) — 350 N Sam Houston Parkway, Suite 120, Houston 77060, (713) 591-2438.

Houston (South) — 2320 LaBranch St, Suite 1103, Houston 77004, (713) 750-1727.

Lubbock — 1205 Texas Ave, Suite 421, Lubbock 79401, (806) 743-7681.

cords shall be made available to the ıbject employee, anyone having writ- n consent of the subject employee, ıd the director of the National Insti- ıte for Occupational Safety and ealth (or designated representative). addition, an employer must remove ıy personal identifiers from informa- on relating to bloodborne pathogens ntained in an OSHA 200 log before anting access to such log. Although ot mandated by the standard, the eation of a plan to ensure the nfidentiality of employee medical cords is strongly encouraged.

Unlike employee medical records, nployee training records are not quired to be kept confidential. pon request, training records are be provided to employees, em- oyee representatives, the director the National Institute for Occu- tional Safety and Health (or desig- ted representative), and the assis- nt secretary of labor for ccupational Safety and Health (or designated representative).

nployment duration plus 30 years

physician/employer must keep an nployee's medical records for the uration of employment plus 30 ars. For purposes of this require- ent, the standard makes no distinc- on among temporary, permanent, ll-time, and part-time employees. aining records, on the other hand, ust only be kept for 3 years from e date on which the training oc- rred. If a physician/employer ceas- to do business and there is no suc- ssor employer to retain the medical ıd training records in accordance ith the standard, the employer must ansmit all of the covered medical ıd training records to the director the National Institute for Occupa- onal Safety and Health (or a desig- ted representative).

Does your office meet OSHA standards?

Hugh M. Barton, JD
TMA Assistant General Counsel

On March 6, 1992, the Occupational Safety and Health Administration released information about its enforcement procedures for the bloodborne pathogens standard. These consist of instructions designed to establish policies and provide clarifications to ensure uniform inspection procedures. This article addresses only OSHA inspections for the bloodborne pathogens standard.

Q: What things will an OSHA inspector want to see in my office?

A: The OSHA inspector will want to review your office's exposure control plan and interview your employees to determine the degree of compliance with the bloodborne pathogens standard. If your office has a file of "incident reports" or a first aid log of injuries, the inspector will want to see this, too.

Q: What will the OSHA inspector look for in my exposure control plan?

A: The exposure control plan will be reviewed for several elements:

- Those job classifications in which all employees have occupational exposure.
- Those job classifications in which some employees have occupational exposure. For these employees, the specific tasks that have occupational exposure must be delineated.
- Exposure determinations must be made *without* taking into consideration the use of personal protective clothing or equipment.
- The schedule and method of implementation of the compliance, hepatitis B vaccination, hazard communication to employees, and recordkeeping requirements must be included in the exposure control plan. It may be adequate for small offices to have a copy of the final federal rules with dates of compliance written on it.
- The exposure control plan must detail procedures for evaluating exposure incidents.
- The exposure control plan must be available to employees within 15 days upon the employee's request.

Q: What records will I have to keep to satisfy the OSHA bloodborne pathogens standard?

A: OSHA is particularly interested in records of "occupational bloodborne pathogens exposure incidents." These include all needle sticks, lacerations, or splashes of blood or other body fluids and are considered to be injuries. These are to be recorded if any one of the following occurs: it is work-related; the incident results in a recommendation for medical treatment beyond first aid, regardless of dosage; and a diagnosis of seroconversion occurs.

Q: How is a worker's serostatus to be recorded in OSHA records?

A: The serological status of an employee is not to be recorded in the record. It should be recorded only as an injury (eg, "needle stick") with the date it occurred.

Q: How do I know which employees are covered by the bloodborne pathogens standard?

A: Your employees are covered if, as a result of job duties, they have "reasonably anticipated" skin, eye, mucous membrane, or parenteral contact with blood or other potentially

infectious materials. The term "reasonably anticipated" includes the *potential* for exposure as well as *actual* exposure. Thus, the lack of history of blood exposures for first aid personnel does not preclude coverage, since there is always a potential.

Q: What practices are acceptable for compliance with the universal precautions requirement?

A: While "universal precautions" — the concept of bloodborne disease control that requires all human blood and other materials to be treated as if known to be infectious for HIV or HBV regardless of the perceived low risk of the patient — is OSHA's accepted method of control; an acceptable alternative is "Body Substance Isolation" (BSI). BSI defines all body fluids and substances as infectious and is broader than the bloodborne pathogens standard. What is *not* acceptable to OSHA is the policy of treating the blood or other materials of some patients as potentially infectious and the blood or other materials of other patients (such as children or the elderly) as not infectious.

Q: What else will the OSHA inspector look for?

A: Through interviews and observation, the inspector will determine whether proper engineering and work practice controls are being followed, such as the immediate disposal of used needles into a sharps container. A citation may be issued when there is a failure to use proper work practice controls, with an additional citation if the inspector decides that inadequate training caused the failure. Further, a citation may be made if there is no system for the regular checking of the work practice controls.

Q: How does a surgeon perform procedures that minimize splashing, spraying, spattering, and generation of blood droplets in accordance with OSHA guidelines?

A: Although surgical power tools, lasers, and electrocautery devices may generate aerosols, OSHA does not believe that current data support the mandatory use of respiratory protection for aerosol exposure, nor does OSHA believe that there is an effective engineering control to address aerosol exposure. However, OSHA does support the use of eye protection and a mask or a face shield.

Q: I know that I am responsible for providing my employees with "personal protective equipment" such as laboratory coats, gloves, scrubs, and the like. Can the employee take these items home for cleaning?

A: No. Home laundering is not permitted by OSHA because an employer cannot guarantee that proper handling or laundering procedures will be followed. OSHA will find a violation if the employer does not clean these garments or cleans them but charges the employee for the cleaning. OSHA will also find a violation if the employer charges an employee for repairs or replacement of the garment or other protective device.

Q: Exactly what things are considered to be "regulated waste" that require special care in disposal?

A: Although OSHA has not determined the degree of infectivity of certain medical wastes, the following categories, at a minimum, require special handling:

- liquid or semiliquid blood;
- items contaminated with blood or other potentially infectious materials that would release these substances in a liquid or semiliquid state if compressed;
- items caked with blood or oth potentially infectious materia that are capable of being releas during handling;
- contaminated sharps; and
- pathological or microbiologic wastes containing blood or oth potentially infectious materials.

OSHA inspectors are instructe never to squeeze or shake a bag waste to determine the potential f release of blood or other potential infectious materials during an i spection. While OSHA specifies ce tain features of regulated waste di posal, the ultimate disposal metho is the responsibility of the Enviro mental Protection Agency and sta regulations.

Q: My medical office is small. How do comply with the regulated waste dispos rules?

A: If only a small volume of regula ed waste is generated, that was may be placed in a large holdi container until the container is fille The container must be designed retain the waste over an extend time between pick-ups by a specia ized waste service. The OSHA i spector will check for visual signs leakage during handling, storage, transport.

Q: I have a professional association. H will the enforcement procedures affe me personally?

A: OSHA considers physicians wh are members of professional associ tions to be employees of the corp rate entity. Thus, the profession association may be cited for viol tions affecting employed physiciar such as failure to provide the hepa tis B vaccine to themselves. On t other hand, physicians in solo pra

ce are not "employees" under the ccupational Safety and Health Act; ıus, a physician will not be cited if e or she is the only person who has ı occupational exposure. Nor will physician be cited if he or she is a artner in a medical partnership. ote, however, that this applies only the activities of the physicians ıemselves. To the extent that the hysicians employ other persons ıey will be responsible for compliıce with OSHA requirements relave to those employees.

: I know I have to provide the hepatitis vaccination to my employees beginning ıly 6, 1992. What are the rules for this?

: OSHA requires that the vaccine, r more precisely, the series of vacciations be provided at no cost to the mployee. This means no "out of ocket" cost to the employee. An mployer may not require the emloyee to use his or her health insurıce to pay for the vaccination se-es unless the employer bears the ost and there is no deductible or opayment to the employee for the ries. The employer may not have a olicy of requiring the employee to ay for the series and be reimbursed y the employer if the employee is mployed for a specified period of me. Finally, a contract under which ıe employees reimburse the emloyer for the cost of vaccination if ıey leave employment prior to a ecified time is prohibited.

egal articles in Texas Medicine *are intended help physicians understand the law by oviding legal information on selected topıs. These articles are published with the unrstanding that TMA is not engaged in proding legal advice. When dealing with ecific legal matters, readers should seek astance from their attorneys.*

Physicians have a place to take concerns under new UR rules

At press time for Texas Medicine, *the utilization review rules (Texas Insurance Code, Article 21.58A and 28 TAC 19.1701–19.1718) were going before the Texas Department of Insurance Commission. The rules were to be published in the* Texas Register *allowing for a 30-day comment period.*

PHYSICIANS WILL BREATHE a little easier when the state's utilization review (UR) law goes into effect this month giving the Texas Department of Insurance authority over a previously unregulated industry.

"Utilization review is here to stay," says C.J. Francisco III, JD, Texas Medical Association assistant general counsel. "A formal structure is now established to give doctors an opportunity to have input on the UR process and to provide a place to file a grievance."

Emerging as part of the 72nd Texas Legislature's insurance reform bill (House Bill 2), the TMA-backed legislation is expected to address the abuses and hassles previously experienced by physicians and patients during the UR process. Signed into law by Gov Ann Richards, the law applies to utilization review conducted on or after June 1, 1992.

Prior to the UR legislation, physicians were placed in a bind when they had legitimate concerns about medical procedures being questioned by a fourth party reviewer.

"They would go to the insurance company with questions about the review and then were told to go to the fourth party reviewer," says Mr Francisco. "The reviewer would say they just work for the insurance company; therefore, the doctor should go to the insurance company.

"It was like being in a traffic circle with an entrance and no exit. The state insurance board couldn't take complaints because at that time they didn't have authority over the reviewers. In the meantime, while this was all occurring, the care of the patient was placed in jeopardy."

Complaints concerning utilization reviews should be sent in writing to Claims and Complaints, Texas Department of Insurance, Mail 111-1A, PO Box 149104, Austin, TX 78714-9104.

Major components of the law include:

- Utilization review decisions must be based on accepted current medical criteria.
- Personnel conducting the review must be appropriately trained, qualified, and if applicable, currently licensed.
- Unnecessary or unreasonable repetitive contacts with the doctor or patient by the UR agent are prohibited.
- Health-care providers must be reimbursed for providing medical information in writing, including copying and transmitting any requested patient records or other documents.
- Unless approved for an individual patient by the provider of record or modified by contract, the UR agent cannot observe, participate in, or otherwise be present during a patient's examination, treatment, procedure, or therapy.
- An adverse determination by the UR agent must include: reasons for determination; description of the

source of the screening criteria that were utilized as guidelines in making the determination; and description of the procedure for appeal. The notification must be provided within 1 working day by telephone or electronic transmission to the patient's physician in the event the patient is hospitalized, or within 3 working days in writing to the doctor and the patient if the patient is not hospitalized at the time of the adverse determination.

- When the UR agent is questioning the medical necessity or appropriateness of a health-care service, the doctor who ordered the service will be given a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the UR agent's decision with a physician. The UR agent will have a written procedure describing the above process.
- A clear and concise statement of the clinical basis for the adverse determination must be provided to the physician if an appeal is filed based on the decision.
- If the physician's appeal is denied and within 10 working days the physician provides in writing a good cause for having a particular type of specialty provider review the case, the denial shall be reviewed by a doctor in the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for the review of the adverse determination.
- UR agents must have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both time zones, if applicable, in Texas to discuss patients' care and allow response to telephone review requests. The telephone system must be capable of accepting or recording or providing instructions to incoming calls other than during normal business hours and respond to the calls no later than 2 working days.
- The confidentiality of individual medical records must be preserved to the extent of the law by the UR agent. The UR agent's procedures must provide that specific information exchanged for the purpose of conducting utilization will be considered confidential, be used by the private review agent solely for the purposes of utilization review, and be shared by the UR agent with only those third parties who have authority to receive such information, such as the claim administrator.

Neglecting informed consent is fuel for malpractice suits

Bernard D. Hirsh, JD
Wildman, Harrold, Allen & Dixon
Chicago, Ill

Donald P. Wilcox, JD
TMA General Counsel

When malpractice lawyers can't prove negligent medical treatment, their fallback position is that the doctor neglected to obtain the patient's informed consent — that the plaintiff's injuries resulted from risks that the physician should have disclosed and the patient would have been unwilling to accept.

Typically, the patient has signed a consent form, often provided by a hospital nurse or admitting clerk, which states that the doctor has fully explained the nature and risks of the procedure to be performed. The patient in turn denies that any discussion of risk of injury from the procedure too place. It then becomes a battle of credibility, whether the jury will believe th doctor or the patient. The rule of sympathy, rather than the rule of law, ma tilt the balance in cases where the patient has sustained serious injury suc as brain damage, paraplegia, death etc, as a consequence of a medical o surgical procedure.

Source for malpractice actions

In the past 20 years, failure to dis close medical risks has become major and steadily increasing sourc for recovering damages in malprac tice actions. Juries have awarde verdicts in cases where they have ab solved the doctor of allegations o medical negligence only to find hin or her guilty of negligence in failin to adequately disclose medical risks Settlements and judgments arisin out of claims that the doctor faile to disclose risks that have occurred and which the patient would hav been unwilling to accept, accoun for a substantial portion of the cos of malpractice insurance.

The most skillful, cautious, an dedicated physician, being human may sometimes make a mistake tha the legal process will adjudge to b negligent treatment. But, with fev exceptions, medical professional lia bility claims based upon lack of in formed consent are avoidable. Jurie may choose not to believe a docto who testified that he or she orall explained the risks and benefits of proposed procedure. Patients unde the pressure of illness, or simple for getfulness, may not recollect tha along with encouragement the doc tor warned about inherent risks i the procedure.

Claims alleging lack of informe consent are usually dismissed b

ımmary judgment without the need ›r a trial where comprehensive writ- :n information in lay language was ıven the patient within a reasonable me before the procedure was sched- led. Showing videotapes in the doc- ›r's office, such as those describing ıe benefits and risks of cosmetic rocedures or prenatal and postnatal ıre, are valuable aids to good medi- ıl practice but they are no substitute ›r consent forms that in lay lan- uage describe the nature of the pro- edure, risks, and benefits that may e reasonably anticipated. In lieu of omprehensive consent forms, writ- en materials providing such infor- ıation may be referenced in the con- ent form. A copy of the signed onsent form, as well as written ex- lanatory literature, should be given › the patient at least a day before a rocedure is to be performed. The atient should also sign a receipt that e or she has received the documents.

Under current practice, patients re not given duplicate copies of the ocuments they sign either in the octor's office or when admitted to he hospital. There is little wonder, hen, that malpractice plaintiffs so requently do not remember signing onsent forms or claim that they vere given no opportunity to read he forms they signed.

A word of caution: exceedingly pbeat written materials, advertis- ng, and videotapes that are de- igned more to sell a doctor's ser- ices than to provide balanced risk nformation can destroy a doctor's lefense to allegations of failure to dequately disclose risks.

In recent years, the medical pro- ession has encouraged physicians to ›articipate in risk management sem- nars aimed at improving the quality ›f patient care and eliminating med- cal mistakes. Generally, but with some exceptions, similar attention has not been given to developing effective written materials to eliminate malpractice claims based upon failure to disclose risks and alternative methods of treatment. Too many doctors delegate to office or hospital personnel the task of obtaining signed consents from patients. Many avoid discussing hazards of medical, diagnostic, or surgical treatment that might cause a patient to reject a medically indicated procedure.

Informed consent rejects concepts that the truth may be injurious to the patient or that the patient has placed himself or herself in the custody of the physician. The gist of informed consent is shared decision-making, and the doctor's duty is to disclose material risks. If possible, standardized written information should be provided to patients a day or more before the procedure is to be performed.

Too many doctors delegate to office or hospital personnel the task of obtaining signed consents from patients.

Medical societies can easily assemble the expertise to provide reliable patient information materials for their members. Based upon prior experience, patient information documents prepared by medical organizations would command a high degree of credibility with judges and juries. In Texas, this has been accomplished through specialty society input into the legislatively created Texas Medical Disclosure Panel (TMDP). Physicians enjoy the presumption that informed consent was provided when they take advantage of the TMDP forms (1). Failure to use the forms developed by the panel results in the presumption that informed consent was not provided.

Vaccine risks and benefits

Beginning April 15, 1992, physicians were required to provide information on the risks and benefits of certain vaccines administered to their patients. The Public Health Service Centers for Disease Control final rules provide the information that must be provided to those immunized against diphtheria, tetanus, and pertussis (DTP); measles, mumps, and rubella (MMR); and polio (2). The Texas Department of Health has provided "Vaccine Important Pamphlets" implementing this law to all physicians licensed in Texas.

The process of informed consent, although time-consuming, is one that physicians cannot afford to delegate. Discussion, the opportunity to ask questions, and providing the patient with written information in advance of treatment are all part of the informed consent process. The goal is to foster the patient's understanding of proffered medical services that he or she is at liberty to accept or reject. Good communication does more than provide legal protection; it enhances the quality of patient care.

Providing the patient in advance of treatment with comprehensive written information in the form of a brochure or leaflet explaining risks, benefits, and alternative methods of treatment, accompanied by a signed consent acknowledging receipt of this information, discourages lawyers from accepting claims alleging lack of informed consent. In litigation where failure to disclose risks is alleged, good documentation that defies challenge will enable the de-

fendant to obtain summary judgment, dismissing the action without incurring the costs of a lengthy trial.

Disclose risks to avoid litigation

The following cases, taken from numerous recent appellate court decisions, illustrate instances in which the doctor could have avoided litigation or at least would have successfully defended the case if he or she had provided the patient with adequate information in advance of treatment. Bear in mind that reported appellate court medical liability decisions represent considerably fewer than 1% of all malpractice claims.

Texas law requires HIV-positive physicians to advise their patients when performing exposure-prone procedures.

— In a Texas case, a hospital nurse obtained the signed consent of the patient to a carotid endarterectomy from which the patient suffered complications. The court held that only the operating physician, and not the hospital or other physician involved in the diagnosis and/or treatment of the patient's condition, had the duty to obtain the patient's informed consent (3).

— In another Texas case, a physician who performed a leg-lengthening procedure on a patient had a common law duty to disclose to the patient all the risks and hazards that could influence a reasonable person in making a decision to consent to the procedure (4).

— In another case, a surgical procedure performed by the defendant physician involved inserting an inflatable penile prosthesis. Gangrene developed in the penis tissue, and after two more operations, the penis was almost completely amputated. The Oregon Court of Appeals held there was sufficient evidence to sustain the jury's finding that the surgeon failed to advise the patient of alternative forms of treatment and of the risks and dangers of surgery (5).

— In *Foard v Jarman*, the plaintiff, who became very ill from complications following gastric reduction surgery, brought suit against the defendant physician claiming lack of informed consent (6). The trial court granted the defendant's motion for summary judgment and the Court of Appeals reversed. The North Carolina Supreme Court in turn reversed the Court of Appeals decision and held that the defendant physician made a sufficient showing of informed consent to prevail on summary judgment.

On the patient's first visit to the doctor, he gave her a booklet, "What You and Your Family Should Know about Gastric Operations for the Treatment of Obesity." The doctor asked the patient to read the booklet and discuss the operation with her family before seeing him again in 2 weeks.

On deposition, the patient testified that she had read the booklet several times, including the section that discussed the risks of the surgery. She disputed the doctor's contention that he had verbally discussed with her the risks of gastroplasty surgery during her office visits. The court noted that it was undisputed that the doctor gave the patient a booklet that described "the gastroplasty procedure in readily comprehensible terms" and that a section explained the risks of wound infection, leaks or perforations, an death. Ruling in favor of the physi cian, the court upheld the tria court's order of summary judgment.

— Whether the defendant physi cian adequately warned the mothe of possible dangerous side effects o diphtheria, pertussis, and tetanu vaccine given her child, and whethe such warning would have averte the disabling, convulsive episod that left the child brain damage was a question for the jury (7). Sinc April 15, 1992, using the Center for Disease Control forms for vacci nations virtually can eliminate in formed consent problems associate with vaccinations.

— In another case, a lengthy jur trial found that the defendant physi cian was not negligent in the actua performance of a pericardiocentesi test. However, the jury did find fo the patient on an "informed consent theory. Cross-examination of th physician at trial confirmed the pa tient's contention that the physicia had not provided sufficient informa tion to obtain an informed consent The Supreme Court of Rhode Islan affirmed the jury's verdict (8).

— A patient stated a cause of ac tion for lack of informed consen based upon allegations that th physician failed to disclose that pri or to obtaining the patient's consen to surgical removal of the patient' spleen, the physician made arrange ments to obtain portions of th spleen. The physician wanted also t have regular and continuous acces to the patient's unique and rar blood and bodily substances for re search purposes (9).

— The New York Supreme Court Appellate Division, found that th evidence supported a jury verdict fo the patient, based on lack of in formed consent, who suffered fron

ermanent diplopia following eye ırgery. The trial court found that ıe physician failed to disclose to the atient the material risks, benefits, nd alternatives to surgery that ould have been disclosed by a rea- ɔnable medical practitioner. The evi- ence also was sufficient for a jury to ɔnclude that an informed, reason- ɔly prudent person would not have ɔnsented to the surgery (10).

— The Louisiana Court of Ap- eals agreed with the trial court that ıe physician failed to advise the pa- ent adequately that bowel and blad- er dysfunction was a risk of lumbar urgery. A bland statement in the ɔnsent form that the surgery had the sk of "loss of function of body or- ans" was not understandable com- ıunication of the risk of being ren- ered permanently incontinent ırough loss of bladder control. The atient established that a reasonable atient would not have consented to ıe treatment if this material infor- ıation and the risks had been dis- losed. The Court of Appeals also greed that the physician's failure to isclose his chronic alcohol abuse vi- lated informed consent require- ıents (11). The court reasoned that ıe substance abuse problem created material risk associated with the urgeon's ability to perform.

— In contrast to the previous ase, the Superior Court of Pennsyl- ania affirmed the trial court in hold- ıg that the parents of a child who ied following surgery did not have a ause of action for lack of informed onsent arising when they were not ıformed of the surgeon's alcoholism nd unlicensed status (12).

Texas law now requires physi- ians who are HIV positive to advise ıeir patients when performing ex- osure-prone procedures (13).

Based upon a survey of recently reported malpractice court decisions in the United States, providing patients with written information as part of the consent process is an effective means for avoiding claims alleging failure to disclose material medical risks. If the Texas Medical Disclosure Panel has developed a form for the procedure contemplated, use of that form is strongly advised. Additional written disclosure information is also advisable to assure that documented informed consent was obtained prior to the treatment or procedure.

References

1. See "Medical Disclosure Panel Adds Radiation Therapy to List A." *Tex Med.* 1990;86;48–56.
2. 42 CFR Part 110.
3. Ritter v Delaney, 790 SW 2d 29 (Tex App — San Antonio 1990).
4. Knapp v Eppright, 783 SW 2d 293 (Tex App — Houston 1989).
5. Wenger v Oregon Urology Clinic, 796, P 2d 376 (1990).
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8. Medeiros v Yashar, 588 A 2d 1038 (1991).
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10. Koller v Manhattan Eye, Ear & Throat Hospital, 563, NYS 2d 497 (1990).
11. Hidding v Williams, 578 So 2d 1192 (La App 1991).
12. Kaskie v Wright, 589 A 2d 213 (Pa Super 1991).
13. Texas Health and Safety Code, § 85.204(c), Vern Tex Civ Stat. ★

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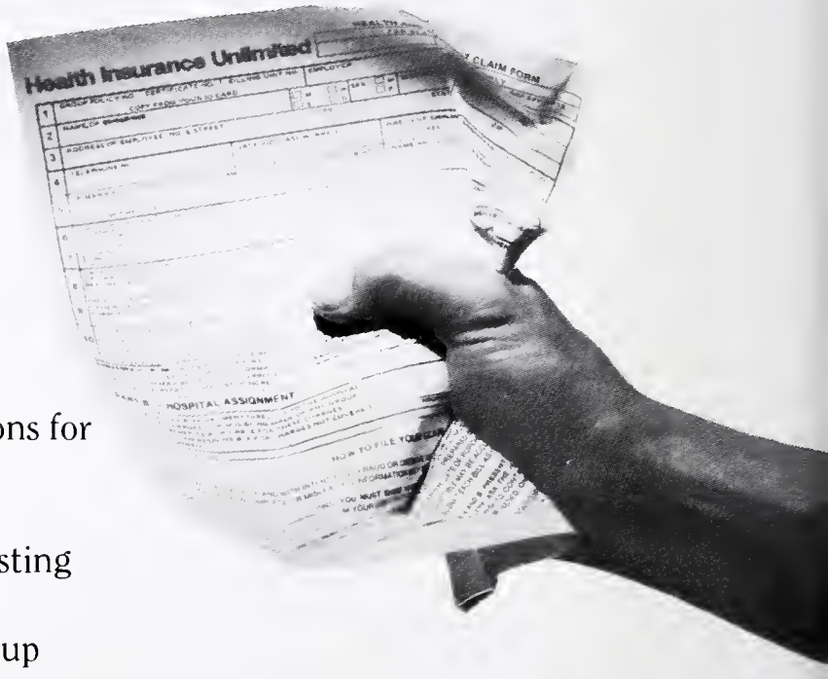

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TB waging attack on HIV-positive patients and jail inmates

TUBERCULOSIS IS ALIVE AND well in Texas. In hopes of finding methods to combat this disease that is emerging from the past, the Texas Department of Health (TDH) reminds physicians to report all suspected and confirmed cases.

"Tuberculosis can be prevented effectively," says Robert J. Awe, MD, member of the Texas Medical Association Council on Public Health. The associate professor of clinical medicine at Baylor College of Medicine says he is seeing an increasing number of TB cases in HIV-positive patients and Hispanic immigrants.

"We need to raise the index of suspicion in physicians," says John A. Bybee, director of the Tuberculosis Elimination Division at TDH. "If a physician suspects a case of TB, it needs to be reported so an investigation by TDH can begin."

Although hospitals have historically been the ideal setting for the transmission of TB, Mr Bybee says jails are now a major site for tuberculosis infection. The Texas Department of Criminal Justice reported 66 cases of TB in 1990. Homeless shelters also are experiencing an increase in TB cases.

The TDH Tuberculosis Control Program has a goal of eliminating the disease in Texas by 2010; however, there were 2,525 cases reported in 1991, reflecting an increase over the 2,242 cases reported in 199(Houston led the state with 522 case in 1990, followed by Dallas, 22? San Antonio, 131; El Paso, 101; an Austin, 100.

"The present program is not con trolling tuberculosis," says Mr Bybe "We are nowhere near eliminating it.

Treatment compliance by patients i one of the major obstacles facing physi cians. It's when patients fail to complet drug therapy that drug-resistant strain of tuberculosis then develop.

"So far, drug-resistant tuberculo sis is a problem in major urban area where there is a lot of HIV-infectio and drug abuse," says Dr Awe.

Another problem in treating pa tients with TB has been the unavail ability of streptomycin (SM) an para-aminosalicylic (PAS) in th United States because they contai an ingredient that did not meet Foo and Drug Administration standards The FDA says SM and PAS will b available in October. Emergenc supplies can be obtained from th Centers for Disease Control.

High risk groups for tuberculosis

- HIV-infected persons
- Persons in close contact with infectious TB cases
- Individuals with medical conditions that increase the risk of TB
- Low-income populations
- Persons from regions with high prevalence of TB (Asia, Africa, and Latin America)
- Intravenous drug users and alcoholics
- Persons in long-term care facilities (prisons)

Source: Centers for Disease Control

Medical conditions that increase risk of developing clinical tuberculosis once infection has occurred

- HIV infection
- Silicosis
- Abnormal chest radiograph showing fibrotic lesions
- Diabetes mellitus
- Prolonged corticosteroid therapy
- Immunosuppressive therapy
- Hematologic and reticuloendothelial diseases
- End-stage renal disease
- Intestinal bypass
- Postgastrectomy
- Chronic malabsorption syndromes
- Carcinomas of the oropharynx and upper gastrointestinal tract
- Persons 10% or more below ideal body weight

Source: Centers for Disease Control

Doctors join "Way Cool" adolescent health program

"Hello, I'm 13 and haven't startea my period. When do I get my perioa and am I abnormal because I haven't started?"

THAT QUESTION AND OTHER relating to teen pregnancy, eat ing disorders, sports injuries AIDS, alcohol abuse, smoking, skir problems, drug abuse, and depres sion were on the minds of Texa teenagers during "Ask-A-Doc" — a telephone call-in program developec through the Texas Medical Associa

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

Physicians participating in the Jefferson and South Jefferson Medical Society Auxiliaries' "Ask-The-Docs" call-in program were (left to right) Carl Beaudry, MD; Margaret Lang-Williams, MD; Fenwick Watts, MD; Dan Gresham, KFDM television host; Brent Bost, MD; Lulu Smith, MD; and Ned Groves, MD.

ion Auxiliary's "Way Cool" adolescent health project.

Auxiliaries from across the state enlisted the assistance of physicians to respond to health questions as part of Healthier Youth 2000 Day in April. The "Way Cool" campaign was designed by the TMAA's Healthier Youth 2000 Committee in response to concerns about substance abuse, sexuality and pregnancy, psychological disorders, suicide, violence, and trauma.

"If this first year of our Healthier Youth 2000 initiative is a true indication of the interest on the part of today's teens, TMAA is definitely filling an important need," says Amy Wilson, executive director of TMA Auxiliary.

"We had a tremendous outpouring of community support," says Marsha Harrison, president of the Smith County Medical Auxiliary. The "Ask-A-Doc" program generated 500 phone calls with 20 physicians responding to questions in Smith County.

Mrs Harrison says Smith County has the highest teen pregnancy rate in the state, adding that many of the questions received concerned sex, AIDS, and alcohol. Callers remained anonymous during the 2-hour program, which featured physicians from the specialties of family practice, psychiatry, pediatrics, obstetrics, gynecology, and adolescent health.

In Cherokee County, the medical auxiliary sponsored school assemblies that addressed issues pertaining to AIDS education, stress factors, coping techniques, parenting skills, physical fitness, diet, alcohol, drugs, and firearms.

President of the Cherokee County Auxiliary Katherine Newton says "Way Cool" book covers and hotline cards were also distributed. Physicians taking part in the program were Tim Field, MD; Frank Felts, MD; Jerry Newton, MD; and James Lowe, MD.

Close to 400 calls were received during the televised, call-in program sponsored by the Jefferson County Medical Society and Jefferson County and South Jefferson County Medical Auxiliaries. JCMS Auxiliary President Joyce Bosch says there is "a need and interest" in this type of program.

Physicians interested in the TMAA adolescent health program can contact their local auxiliary president or Kitty McMinn Kress, TMAA program director, 401 W 15th St, Austin, TX 78701, phone (800) 880-1300 or (512) 370-1328.

Reducing teen pregnancy rates is goal of summit

IT'S A DISTINCTION TEXANS would prefer not to have. With the state leading the nation in teenage mothers age 14 and under, there's obviously a need for a solution to the problem.

That's why the Texas Summit on Adolescent Pregnancy Prevention will meet in October in Austin to develop a statewide plan to reduce adolescent pregnancy rates by the year 2000. In preparation for the summit, nine regional work sessions were held in May to seek input from many individuals with diverse views on how to address adolescent pregnancy prevention.

"The only way to attack the problem is to have statewide involvement," says James C. Hoyle Jr, MD, chairman of the Texas Medical Association Adolescent Task Force. "I don't think you can 'Austin' this problem. You are going to have to 'Waco-it' and 'San Antonio-it' in addition to taking it all the way down to the small community level. There's not going to be just one solution to the problem. What works in Bexar County may not be the same approach to take in West Texas."

He adds, "I would like the TMA Adolescent Task Force to have some input because the interests of the Texas summit participants are our interests as well."

The summit is sponsored by Gov Ann Richards, the Southern Governor's Association, and Adolescent Pregnancy and Parenthood Advisory Council.

UT-Med schedules OSHA workshops

EDUCATING YOUR STAFF about the OSHA bloodborne pathogens regulations is just one of the many requirements mandated under the new law. In hopes of easing this burden, The University of Texas Health Science Center at Houston has scheduled four workshops throughout the state.

Under the direction of the Southwest Center for Occupational and Environmental Health, the Train-The-Trainers workshops will focus on implementation of the standards, inspection procedures, medical waste management, and legal issues.

Workshops are scheduled in Houston, July 16; Lubbock, July 21; San Antonio, July 31; and Dallas, August 7.

Registration is $175 and information is available by calling (713) 792-4648. ★

AGENDA ON AIDS

Texas mothers testing HIV-positive

Texas Department of Health officials have released figures revealing that 9 out of every 10,000 women in Texas who gave birth in 1991 tested HIV-positive. The numbers are the result of a 4-month study of blood samples from newborns. TDH officials estimated that 285 women, including 86 teenagers, tested HIV-positive.

National Commission on AIDS to meet in Austin

The National Commission on AIDS will hold a public hearing in Austin on July 15–16. Verbal and written comments will be accepted by the commission during the meeting. Physicians interested in the hearing can contact the commission at (202) 254-5125.

Sometimes I am told that the average incubation period for AIDS is 11 years. Other times people say it can be detected in less than 6 months. Which is correct?

Both incubation periods are correct. On the average it takes 11 years for a person who is infected with the human immunodeficiency virus (HIV) to develop the symptoms that will allow him or her to be defined as an AIDS case. However, remember that AIDS is merely the final stage of a long-term infectious process caused by HIV. Through antibody testing, it is possible to detect that a person has been infected with HIV within 6 months of exposure, but the person may not develop AIDS symptoms for a decade or more after infection.

Richard M. Grimes, PhD, director of the AIDS Regional Education and Training Centers for Texas and Oklahoma at The University of Texas at Houston School of Public Health, will provide answers to questions about AIDS each month in this column. For further information about this topic or any HIV topic, call the AIDS Helpline for Health Professionals at (800) 548-4659.

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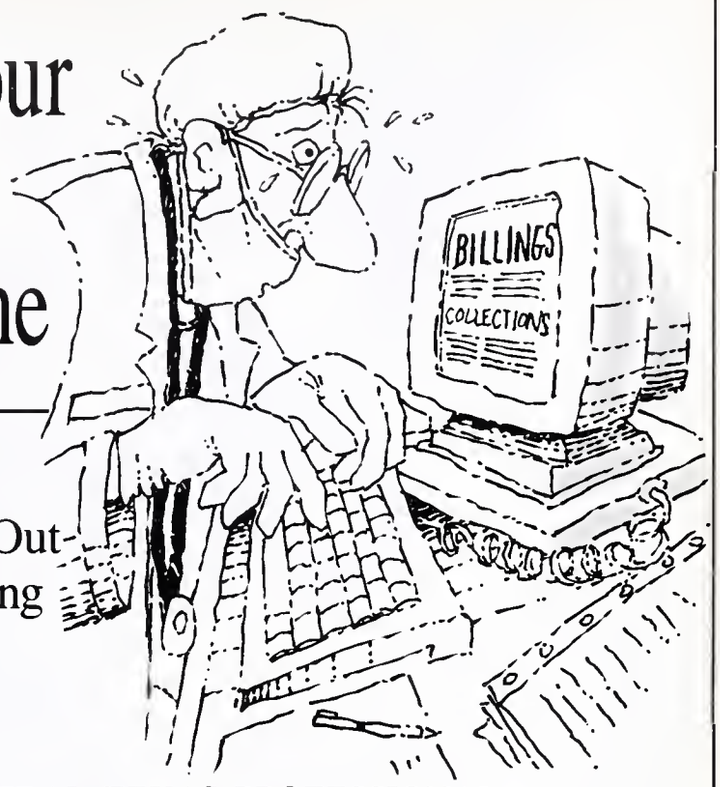

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

The cost of cancer in Texas

Anna Fay Williams, PhD
Charles E. Begley, PhD

Direct and indirect costs of cancer for Texas are estimated for 1988 and are compared to costs for 1980. The distribution of these costs by age group and type of cancer is presented and discussed. Conceptual and methodological issues underlying the estimates are explained to assist the reader in interpretation. The authors conclude that future collection of more specific data at the state level would greatly assist policymakers dealing with cancer issues.

Dr Williams, Research Scientist, Texas Cancer Data Center, HMB 223, 1515 Holcombe Blvd, Houston, TX 77030; Dr Begley, Associate Professor, School of Public Health, The University of Texas Health Science Center, Houston, Tex. Send reprint requests to Dr Williams.

The total cost of cancer in Texas was an estimated $4.4 billion in 1988. This reflects an increase of more than 80% since 1980 (Fig 1). The rise in cancer cost tracks increases in the number of cancer deaths and inflation in medical care costs (Fig 2). The largest component of cancer cost was the loss of future earnings of persons suffering premature death (mortality cost). This cost represented about 68% of the total cost in 1988. The importance of this component has declined somewhat since 1980, relative to direct costs (medical care cost) and the loss of earnings from sick days (morbidity cost) (Fig 3).

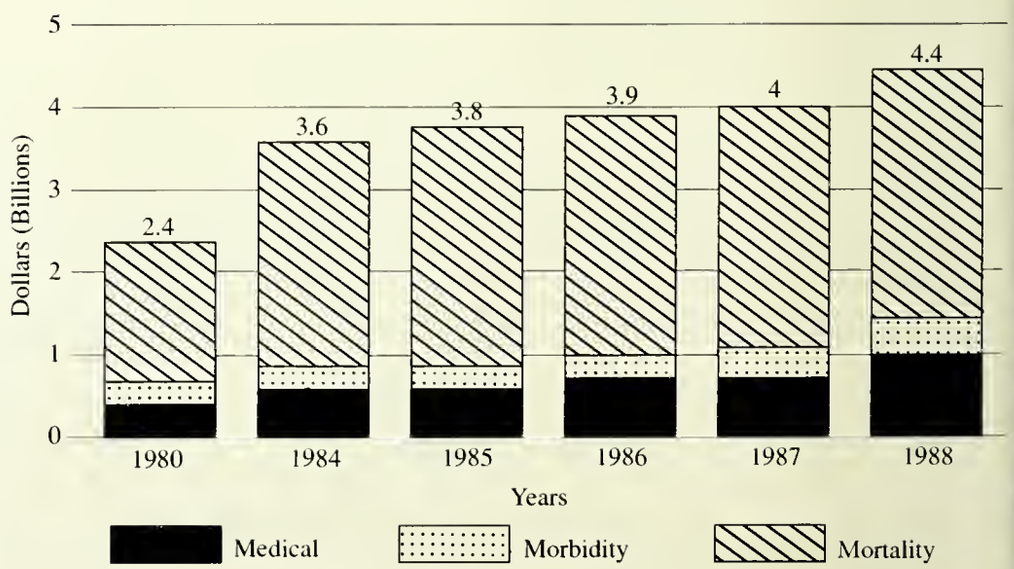
Persons 45 to 64 years old sustained 50% of all cancer cost in 1988. The relative burden of this age group has declined from 53% in 1980, while the costs increased slightly for those older than 65 years (Fig 4). Mortality cost is the largest component of total cost for persons younger than 65. For those older than 65, direct medical care cost accounts for the largest portion (Fig 5).

Lung cancer is the most costly type of cancer, followed by breast and colorectal cancer (Fig 6). Togeth er, these three accounted for approxi mately 41% of total cancer cost i 1988 (Fig 7). The high cost of lun cancer results primarily from mortal ity cost in the group aged 45 to 6 years (Fig 8) and reflects high deat rates and lost earnings. For breas cancer, the largest component of cos was associated likewise with mortali ty cost sustained by the groups bot aged 15 to 44 years and 45 to 6 years (Fig 9). The cost of colorecta cancer is concentrated in the grou aged 45 to 64 years and reflects th high mortality cost (Fig 10).

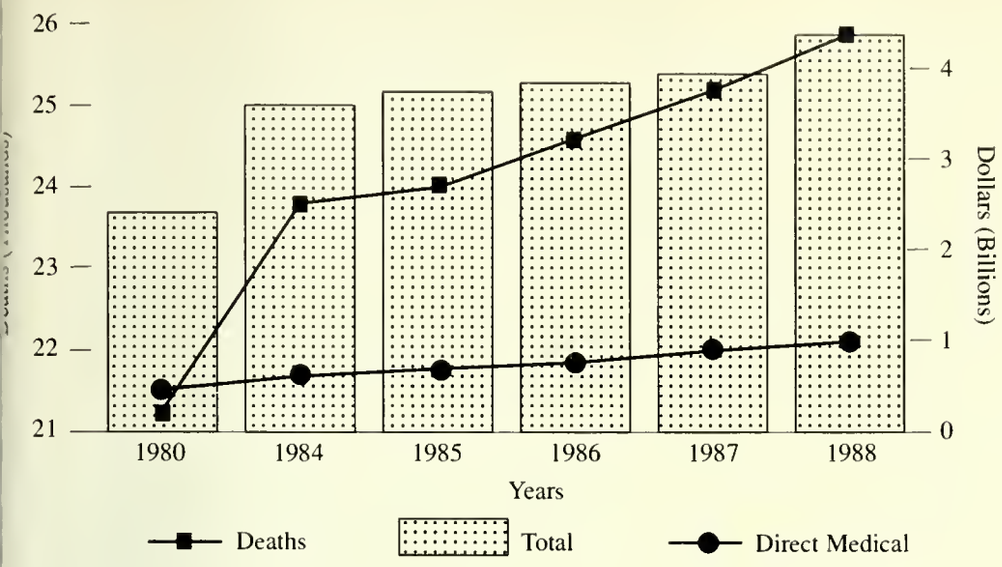
BACKGROUND AND METHODS

The methods for cost-of-illness stud ies were refined and used widely dur ing the 1960s and 1970s with a many as 200 studies published in th literature during that period. Thos investigators most responsible for de veloping and refining the estimatio methods were Rice, Hodgson, an Scitovsky. Rice's 1966 article, "Cos of Illness Methodology," became th major reference (1). Subsequently other articles have elaborated on th estimation procedures (2–7).

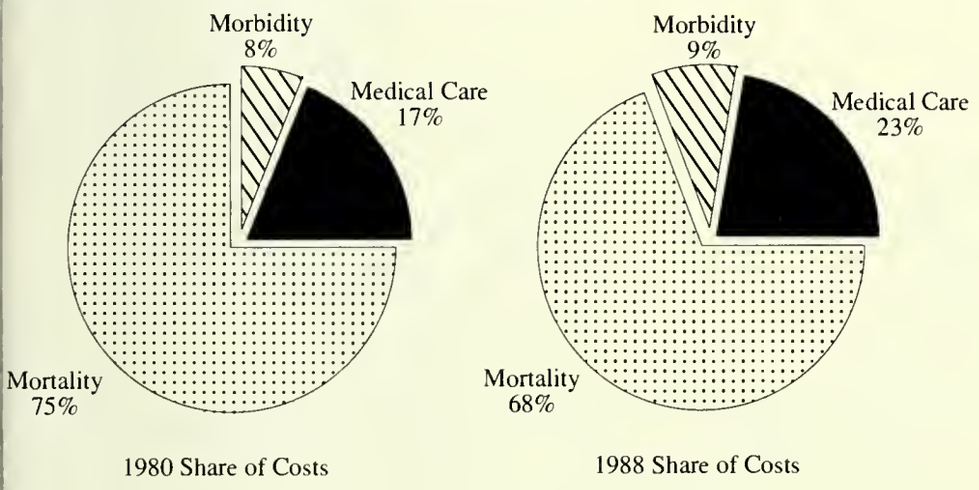
Fig 1. Total cost of cancer in Texas.



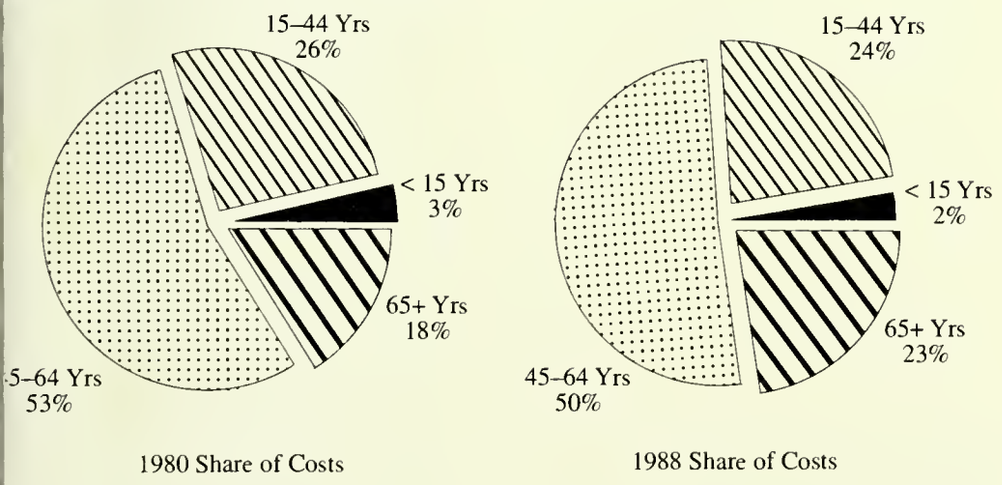
ig 2. Cost of cancer compared with medical cost and deaths in Texas.



ig 3. Share of cancer cost in Texas by type of expenditures.



ig 4. Share of cancer cost in Texas by age group.



For cost-of-illness studies, the pe-iod of time for which estimates are nade and the types of cost that are stimated vary, depending on vhether the prevalence or incidence pproach is taken. The prevalence pproach attempts to estimate all di-ect and indirect costs caused by a disease during a given period. Costs are calculated for all persons receiving treatment for the disease or suffering sickness and death during the period, regardless of when a diagnosis was made. The incidence approach, on the other hand, associates the cost of an illness with the year of diagnosis. The cost estimates represent the total lifetime cost of the illness from the date of diagnosis to the date of death. The prevalence approach is more appropriate for evaluating a program that affects all individuals with the disease or when the value of resources lost during a specific period is a concern (3,8). The incidence approach is appropriate for determining the potential reduction in health costs that would occur if new cases were prevented.

The prevalence approach is used in this study to derive the cost of cancer annually for selected years since 1980. Cost includes direct expenses for medical care associated with treatment received during the year and indirect cost from the loss of current and future income caused by morbidity and premature mortality. Direct cost of medical care includes personal expenditures for hospital care, physician services, nursing home care, drugs, and other professional and health services. Indirect cost includes wages lost by days away from work while alive and by years of work precluded by death. Because of problems with methodology and data, no attempt was made to include the intangible costs of pain or suffering or the economic burden on family members and friends. Therefore, all estimates should be considered conservative.

Direct Cost

Direct cost includes personal expenditures for hospital care, physician services, nursing home care, drugs, and other professional and health services. Direct cost does not include government public health activities or the net cost of insurance, research, or construction. Such nonpersonal expenditures are already reflected in the personal expenses

Fig 5. Cancer cost by age group, 1988.

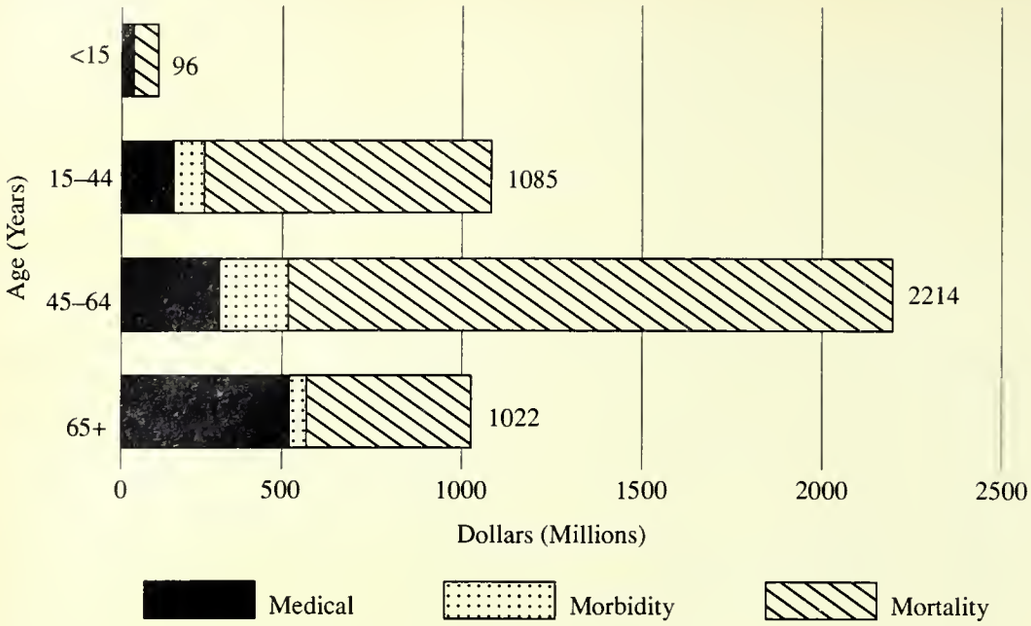


Fig 6. Cancer cost by major type, 1988.

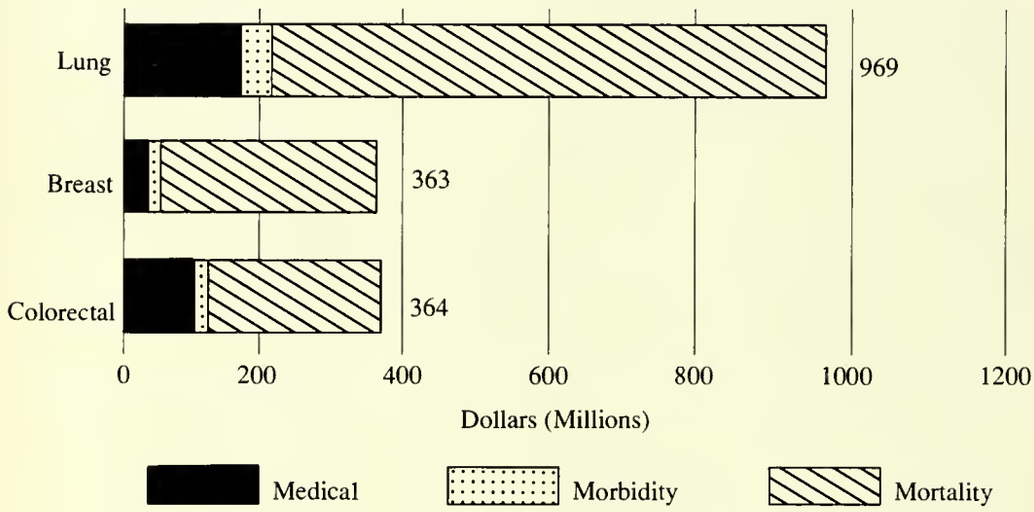


Fig 8. Cost of lung cancer by age group, 1988.

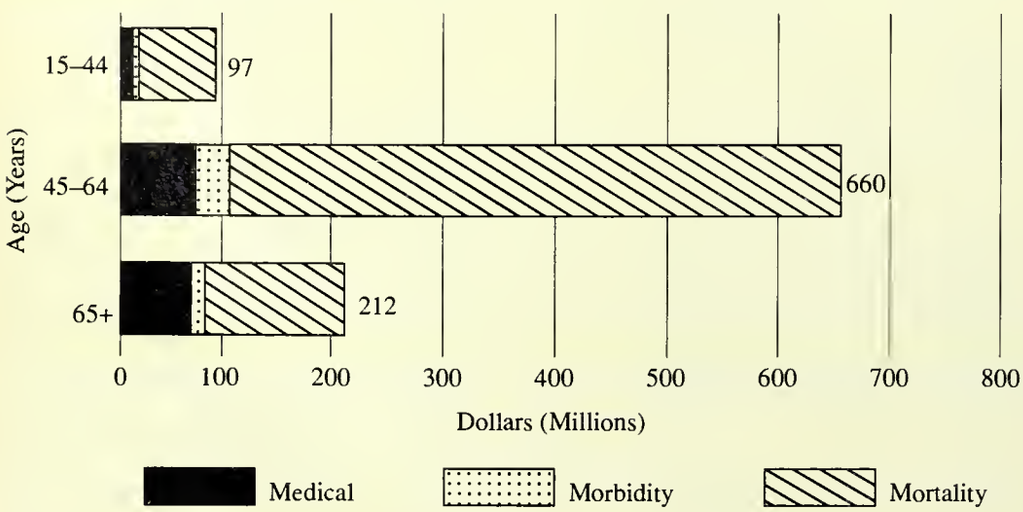
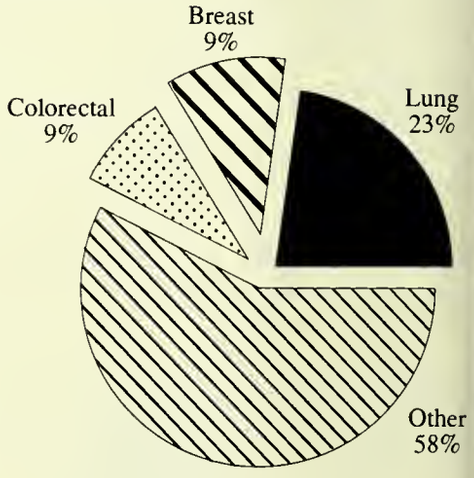


Fig 7. Share of total cancer cost by type o cancer, 1988.

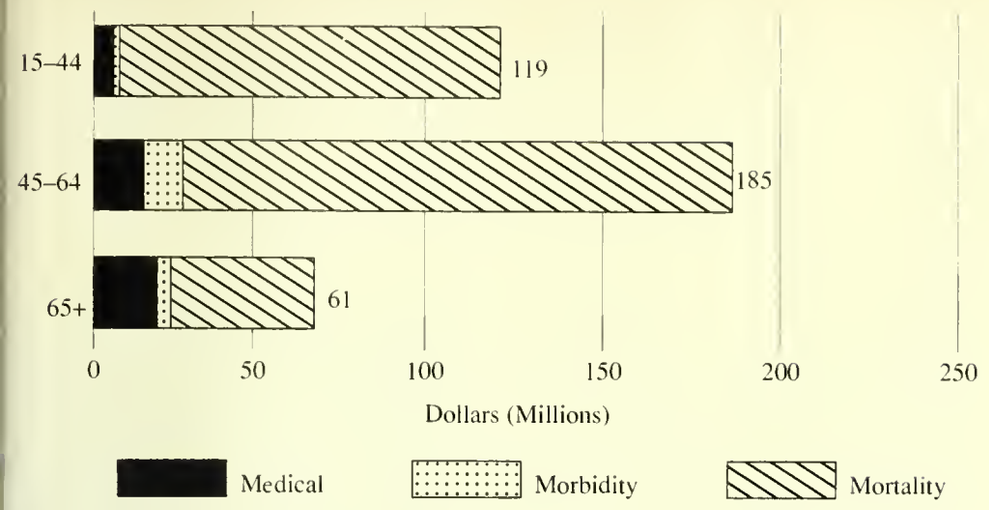


Total cost: $4.4 billion

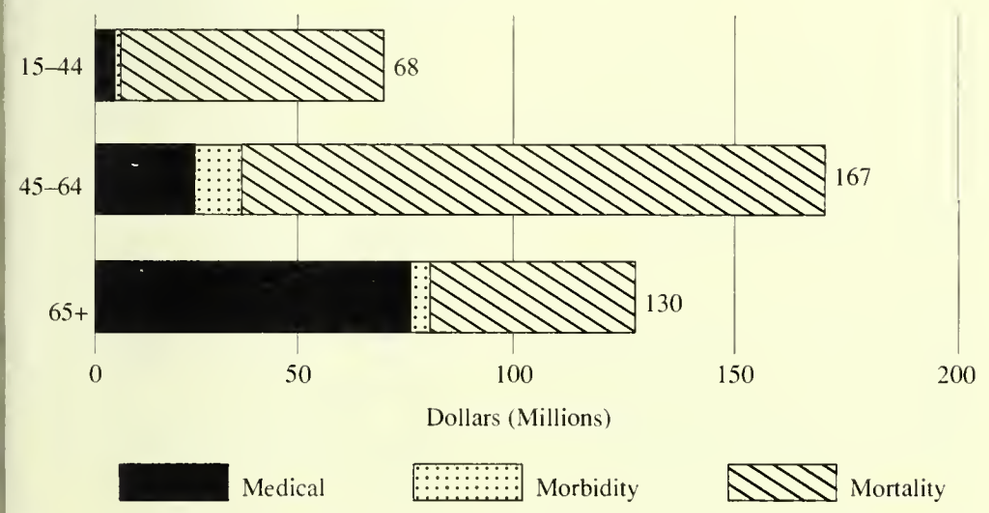
listed above (1,7). A more detailed list of services and supplies for personal care might include emergency assistance, diagnostic tests and radiographs, and other institutional routine and ancillary services such as physical rehabilitation, vocational rehabilitation, home care, supplies and special medical devices (9). Data on these services and supplies were not available for this study.

Two approaches have been used for relating direct cost to a specific illness: disaggregative and aggregative. The disaggregative approach allocates some portion of total health-care costs to an illness based on the prevalence of cases of illness during a given year (2). This approach has been applied in cost-of-illness studies using national expenditures for health care. The aggregative approach begins with estimates of various costs associated with diagnosis and treatment of a single case of a specific illness. The costs per case are then multiplied by the number of cases of illness in the population being studied. With limited sources for national data, most studies use the aggregative approach

g 9. Cost of breast cancer by female age group, 1988.



g 10. Cost of colorectal cancer by age group, 1988.



ith institution-specific, location-ecific, and/or population-specific ta to obtain estimates of cost per se. The aggregative approach was sed for this study.

ospital Care

he direct cost of hospitalization as estimated in three steps. First, tional hospital discharge rates for ncer patients by age/sex groups ere obtained and multiplied by the rresponding age/sex groups of the xas population to derive the num-r of inpatient hospitalizations for ncer. Second, the number of inpa-ent hospitalizations was multiplied the average length of stay (days) r cancer patients to obtain total spital days. Finally, the number of spital days was multiplied by the erage cost per day for stays in mmunity short-stay hospitals.

The International Classification of Disease (ICD), 9th Revision, Clinical Modification Codes was used to identify cancer patients with ICD Codes 140-239, which include benign neoplasms. The length of stay, number of discharges, and discharge rates by ICD-9 codes were obtained from the *National Hospital Discharge Survey*, Vital and Health Statistics, Series 13 (10). The discharge data are available on a national basis by age/sex groupings. Regional estimates by disease categories are available on an aggregated basis but are not broken out by age/sex groupings. State-level breakouts are not available. The Commission on Professional and Hospital Activities publishes national and regional hospital discharges by Diagnosis Related Groups (DRGs) (11). While the DRG data provide more detailed breakouts by age/sex groups, their use is not recommended because it is not clear to what extent DRG categories pick up all cancer diagnoses.

The American Hospital Association's annual report, *Hospital Statistics*, was used to obtain average inpatient per diem costs for community short-stay hospitals because cancer-specific per diem costs are not available (12). The American Hospital Association data are commonly used for this purpose in cost-of-illness studies and are available annually on a state basis.

The average length of hospital stay for cancer patients was obtained from the *National Hospital Discharge Survey*, Vital and Health Statistics, Series 13 (10). This average is given as a rate per 10,000 persons that can be applied to the state population. Similar annual data are not available for nursing homes or long-term hospitals.

Physician services, drugs, nursing home care, and other costs

The direct cost for these professional services and supplies is usually estimated by multiplying the utilization of each category by persons with a given illness by the appropriate cost per unit. However, this approach could not be used in this study because of the lack of state-specific data on utilization and cost of these services. Instead, it was assumed that expenditures on each of these categories by cancer patients is proportionately related to hospital expenditure in the same way that total expenditure on each category was related to total hospital expenditures in a 1985 national cancer cost estimate (13). The national ratios of the expenditures for each category to hospital expenditures were applied to our estimates of hospital expenditures in Texas to estimate the expen-

Table 1. Ratios for estimating other Texas medical care cancer costs.

Expenditures	Percent of Total		Ratios
Hospital	68.3	Physician/Hospital	.41
Physician	28.3	Drug/Hospital	.05
Drug	3.5	Nursing home/Hospital	.05
Nursing home	3.6	Other professional services/Hospital	.01
Other professional services	.8		

ditures for each of these other categories in Texas (Table 1).

Morbidity cost

The cost of days of work lost and lost household services were calculated to estimate morbidity costs. Days of work lost because of cancer were estimated by applying the *National Health Interview Survey*, Series 10 bed disability days by age groups to the employed population in Texas (14). The percent of the lost workdays attributed to cancer was assumed to be equal to the percent that cancer discharges represented of all discharges in the *National Hospital Discharge Survey*. Lost workdays were then multiplied by mean earnings per diem (adjusted for 245 workdays) in each age/sex group; the earnings data were obtained from the US Department of Commerce (15).

The cost of lost household services was estimated using national data on the annual value of household services for those employed and those remaining at home (16). Those estimates, adjusted to a per diem basis, were applied to the estimates of bed disability days for the currently employed and unemployed noninstitutionalized population.

The cost of lost household services for the institutional/disabled population has been estimated in some previous studies (16). However, identifying this population at the state level is difficult. Because the number of cancer patients in nursing homes is estimated to be relatively small (2% to 3% nationally), the elimination of this group was thought to have little effect on the totals (17).

Mortality cost

Mortality cost is estimated by lost earnings. The value of earnings lost by premature mortality is based on expected earnings discounted to their present value for the actual cancer deaths in the state in 1988 (18). These estimates take into consideration life expectancy, participation in the labor force, housekeeping rates, earnings, and the imputed value of housekeeping services for each age and sex grouping. A 4% discount rate was used to calculate present values because of general agreement that discount rates for social decision making should be somewhat lower than those used in valuing private market investments.

PROBLEMS AND LIMITATIONS

While previous estimates of the costs for various cancers have been made, this study represents the first known effort to estimate total cost for all cancers in Texas. Comparisons with previous studies are difficult because of differences in assumptions, methodology, and data. For example, the 1988 report from the Office of Smoking and Health of the Texas Department of Health estimate $350 million (4,496 deaths) (19) fo smoking-related cancer (19). Our es timates for lung cancer cost in 198 came to $969 million (7,39 deaths). The Office of Smoking an Health study attributes a percentag of the actual deaths caused by lun cancer in Texas to smoking preva lence for persons 20 years of age an older and does not include lung car cer deaths due to other causes whereas our study uses all actua deaths from lung cancer in all ag groups as recorded by the state's De partment of Health, Bureau of Dis ease Control and Epidemiology Cancer Registry Division.

The best hope for detecting trend and evaluating the impact of pro grams and policies directed towar prevention lies in a series of data de veloped through a consisten methodological approach. In con ducting this study, problems were er countered with the lack of consister and continuous data, particularly c different resources. Consequentl these estimates are based on man assumptions about the applicabilit of national expenditure patterns t Texas. The cost of hospital treatmer may be challenged since it is base on the average cost per adjusted in patient day in Texas short-term com munity hospitals. It may well unde state the true cost of medica resources used in specialized instit tions for cancer patients. Lifetim earnings may be understated for particular age group as the figure are based on experience from a cros section of the population. It is as sumed that the lifetime pattern c earnings for Texans in a particula age group will follow the pattern i the national cross-sectional data (2).

With these caveats in mind, th reader will get from this study

ugh approximation of the overall st of cancer in Texas. Though the timates are understated, they indi- te the enormity of the problem in ms of treatment costs and of loss- in human productivity. The hur- es encountered in making these es- nates demonstrate the need for tter data regarding the use and st of health care for cancer to see here we are and where we are go- g, and, thus, to be able to make tter decisions for public policy.

KNOWLEDGMENTS

e authors thank Emily F. Untermeyer, ex- tive director of the Texas Cancer Council, l the Texas Cancer Council for their sup- rt of this study. We appreciate the encour- ement of Dr Jack Franklin, director of alth Policy Research and Analysis, The iversity of Texas M.D. Anderson Cancer nter, Office of the Vice President for alth Policy.

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Selective posterior rhizotomy to treat spasticity associated with cerebral palsy: a critical review

Sarah J. Gaskill, MD
Kay Wilkins, MD
Arthur E. Marlin, MD

Selective posterior rhizotomy for the treatment of spasticity has become a widely used procedure. The historical evolution of this procedure is reviewed with an emphasis on the physiological basis for the procedure. The proper screening and selection criteria, perioperative management, operative technique, and postoperative therapy are discussed. Results from a series of 25 patients are reviewed. Ten of these patients were operated on for a goal of improved ease in caretaking and this was achieved. In seven patients, the goal was to improve independent functioning (ambulation was not considered possible) and this was achieved. Eight patients underwent the procedure to improve ambulation and this was achieved.

Dr Gaskill, Division of Neurosurgery, Duke University Medical Center, Durham, NC; Dr Wilkins, Departments of Surgery (Orthopedics) and Pediatrics, Santa Rosa Children's Hospital, San Antonio, Tex, and clinical professor, Department of Orthopedics, The University of Texas Health Science Center at San Antonio; Dr Marlin, Departments of Surgery (Neurosurgery) and Pediatrics, Santa Rosa Children's Hospital, and clinical professor, Department of Pediatrics, The University of Texas Health Science Center at San Antonio. Send reprint requests to Dr Marlin, 4499 Medical Dr, Suite 397, San Antonio, TX 78229.

Selective posterior rhizotomy (SPR) has recently been revitalized as a popular treatment for the spasticity of cerebral palsy (CP). The wide range of therapeutic options for CP not only reflects the spectrum of the disease but also serves to confirm the lack of an ideal treatment. The incidence of cerebral palsy ranges from 2 to 2.5 per 1,000 school-age children; of these, 75% have the purely spastic variety (1). Only a select group of these children have the potential to benefit from the reduction of spasticity through SPR.

This surgical procedure, variations of which have been used intermittently since the early 1900s, is designed to decrease the abnormal tone and, thereby, to facilitate more normal movement patterns. This is accomplished by sectioning "abnormal" posterior rootlets, composed of Group Ia afferents, to restore the lost balance between the descending inhibitory motor tracts and the excitatory anterior horn cells.

HISTORICAL PERSPECTIVE

Abbe and Bennet first described the clinical sectioning of the posterior rootlets in 1889 (2,3). However, Sherrington's work in 1898 provided understanding of the theoretical basis for the SPR (4). In his experiments, he transected the midbrains of cats and monkeys, thereby removing the descending inhibitory pathways and rendering the animals spastic. He subsequently sectioned the posterior roots of the spinal nerves, which relieved the spasticity. From his results, he concluded that decerebrate rigidity depended upon the integrity of the afferent pathways. Thus, by disrupting their continuity with the central nervous system, the spasticity could be relievec

In 1908, Foerster first describ the sectioning of posterior roots humans for treatment of spastici (5). In 1911, he presented a lar clinical series consisting of 109 p tients (6). In 28 patients who we suffering from "gastric crises," se tioning of the posterior rootlets w used to reduce pain. In 81 patient the intent was to reduce spast paralysis. Even at that time, Foerst recognized many concepts that a confirmed today:

> . . . resection of the posterior nerv roots cannot be successful in tl muscular contractions of athetosi chorea, mobile spasms . . . .
>
> We may therefore conclude th the operation can only be su cessful where voluntary excitab ity of the muscles is still prese to a certain extent.
>
> Good results can only be ol tained with very careful exerci treatment . . . continued f years, during which continuo progress may be observed.

In 1913, he presented a follow-u paper outlining the three indicatio for the excision of posterior spin nerve roots: neuralgic pains, viscer crises, and spasticity and spast paralysis (7). His series for root r section to relieve spasticity was co posed of 159 cases at that tim While the results were impressiv the procedure was rarely used un later in the century.

When posterior rhizotomies we subsequently reintroduced, two di ferent variations of Foerster's oper tion were advocated: functional ar anatomical. The introduction some form of selectivity was d signed to avoid the ataxia and exce sive hypotonia noted in some of t

revious patients. In 1967, Gros roposed the partial sectioning of ootlets (8). Eighteen (72%) patients his series of 25 patients obtained excellent" results. His primary conibution was to use a *partial* seconing of rootlets. Fraoli and Benitti also used this method with onsiderable success (9,10).

In the early 1970s, Sindou et al escribed an anatomically selective pproach (11). They advocated seconing nociceptive and myotatic bers while preserving the propriopptive afferents. The problem with is approach is that anatomic selecon disregards functional selection, nd abnormal rootlets may be preerved in the process.

In 1976, Privat and Fasano each escribed the use of electrophysiolgal recordings (EMG) and clinical sponses to create a sectioning that as not only partial but *selective* 2,13). Fasano, however, continued publish his technique and results ith EMG. He continued to promote traoperative monitoring by EMG determine which rootlets caused abnormal response. Four abnorial responses were determined: hose with a decreased refractory me; those with decreased temporal hibition, resulting in tetany; those ith decreased spatial inhibition, hich diffused stimulation to idespread muscle groups; and those at resulted in an after-discharge henomenon. By sectioning rootlets at displayed one of these criteria on imulation, the abnormal rootlets ontributing to spasticity were elimiated. In the series of 80 patients reorted by Fasano et al, only 2% had oor results, 27% had slight imrovement, 52% had good results, nd 19% had very good results (14). he benefit of selectively cutting ootlets was a quantitative reduction in the side effects, with greater preservation of exteroceptive and proprioceptive sensations as well as of sphincter control. This can be explained by the fact that a selective sectioning serves to spare the normal afferent flow, thereby sparing the normal proprioceptive fibers. Furthermore, these investigators felt that the frequency of recurrence rates was reduced because abnormal rootlets were specifically cut, in contrast to a random sectioning, where abnormal rootlets may remain in the circuitry to contribute to postoperative recurrence. Fasano's collective papers have confirmed these findings (13–17).

Fasano's technique has been used successfully by many others since then (18–20). It is the technique used in the series that we present below.

SCREENING AND SELECTION CRITERIA

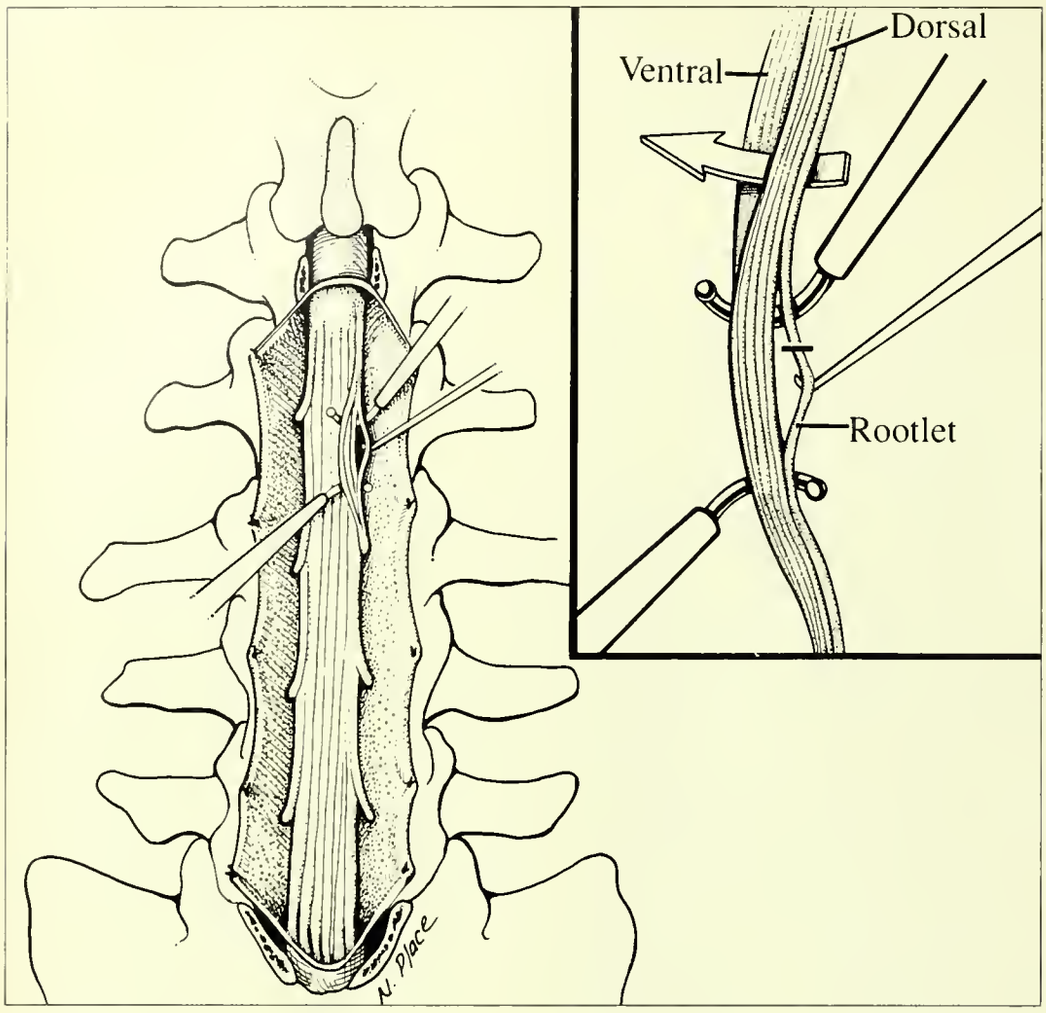
One of the most important aspects of SPR is that it be performed only on the appropriate candidates. Two groups of patients need to be considered. The first group is often dismissed summarily, but we believe its patients can benefit from SPR. This group consists of the bedridden children with severe CP who are also mentally retarded. In these cases, the procedure allows a reduction in tone, which allows easier caretaking and probably more comfort for the child. The second group contains the "ideal candidates." These are children who suffer from CP and who are intelligent, motivated, and primarily spastic.

At Santa Rosa Children's Hospital, we use a protocol for selecting a group of patients with the best chance of benefiting from the procedure. All prospective candidates undergo an extensive 3-hour screening. This process includes evaluation of the following physical capabilities: strength, range of motion, walking with and without shoes or braces, standing (anterior and posterior), bench sitting (lateral), floor sitting (lateral), sitting to standing, creeping, reaching, grasping, range of motion, and isolated joint movements. All these are videotaped and evaluated by a team consisting of a pediatric neurosurgeon and a pediatric orthopedic surgeon as well as physical and occupational therapists. The ideal candidate is purely spastic, has underlying muscular strength, is motivated, and has the appropriate family support to commit to the lengthy postoperative rehabilitation program required to learn normal movement patterns. Boys' ages should range from 3 through 17 years; girls' ages, from 3 through 13.

SURGICAL TECHNIQUE

General anesthesia is induced without the use of muscle relaxants, which might affect the intraoperative EMG monitoring. Electrodes are placed bilaterally in the hamstrings, quadriceps, anterior tibialis, and gastrocnemius. Urinary drainage is established, and the patient is placed in the prone position. A laminectomy or laminotomy is done from L1 to L5 (Fig 1). The dural tube is opened and the S1 and S2 nerve roots are identified anatomically and by electrical stimulation. Under magnification, moving from L2 to S1 bilaterally, the surgeon separates the posterior root from the anterior root. A threshold electrical response for the posterior root is then determined, and the posterior root is separated into rootlets. The rootlets are individually stimulated. The clinical and electromyographical responses are noted. Rootlets causing an abnormal response are sectioned. After the dura

Fig 1. L1–L5 laminectomy with cauda equina exposed. Inset with separation of ventral and dorsal roots separated by arrow. Rootlet separated by nerve hook for stimulation and sectioning.



is closed, an appropriate dose of intrathecal morphine is injected.

POSTOPERATIVE MANAGEMENT

The intrathecal morphine usually controls pain for the first 12 to 24 hours, after which intravenous narcotics are needed for another 12 to 36 hours. Steroids, bed cradles, and stockings are used as needed to help alleviate the dysesthesias that are frequently present for the first 2 or 3 postoperative days. Physical therapy begins on the third postoperative day or as soon as pain tolerance allows. One week after surgery, an aggressive program of physical and occupational therapy is begun. This program is planned preoperatively, depending on the functional goals in each case. To achieve the maximal gains, a well-structured rehabilitation program is essential.

SAN ANTONIO SERIES

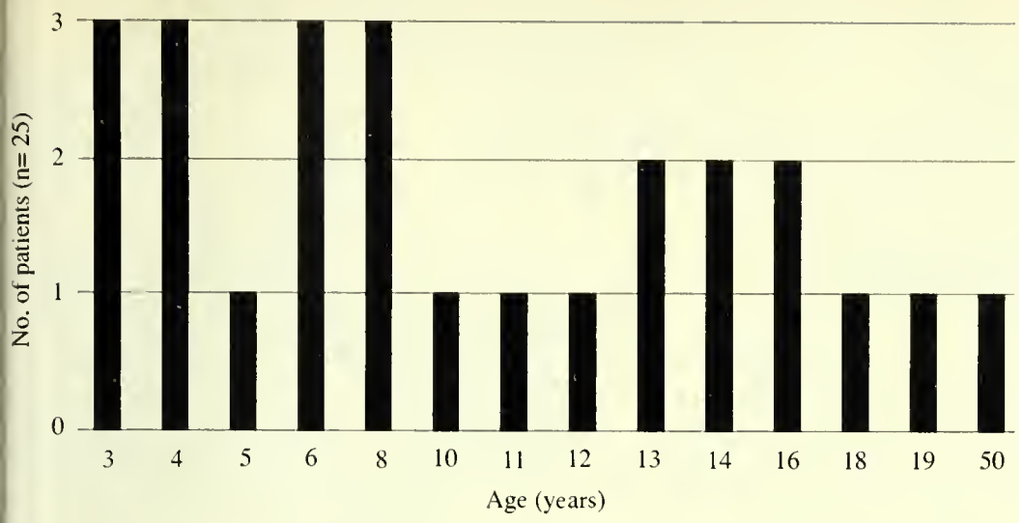
We studied 25 patients (Fig 2) with a follow-up ranging from 6 through 30 months. These patients are best categorized by the desired preoperative goal of surgery. In 10 patients, the goal was to facilitate nursing care, eg, positioning and diapering. These patients were all severely disabled and essentially bedridden. In 7 patients, the goal was to improve independent functioning, but ambulation was not considered realistic. In this group, 5 patients had spina bifida, and the procedure was done at the same time as the release of a tethered spinal cord; 1 patient had a spinal cord injury; and 1 patient had multiple sclerosis with severe flexor spasms. Improved ambulation was the desired goal in 8 patients, 7 of whom had cerebral palsy with a spastic diplegia. We studied 1 patient who had a progressive spinal paraparesis. The ages ranged from 3 through 50 years.

RESULTS

No operative mortality occurred in the series. The only morbidity occurred in a severely disabled child who developed an aspiration pneumonia postoperatively. This child underwent a gastrostomy and fundoplasty before discharge. Realisti functional goals were achieved in a patients. In the severely retarde bedridden group, nursing care wa made easier by allowing better posi tioning and even sitting. In 2 pa tients with recurrent hip subluxa tion, femoral head resections wer done at the same time. Eliminatin the extensor thrusting allowed com fortable sitting. In 2 of these bedrid den patients and in 1 child wit myelomeningocele, persistent hi flexion still existed. In similar case we would now plan to extend th rhizotomy to L1. Except for this sin gle case, the children wit myelomeningocele returned to thei previous functional levels before th onset of spasticity. Severe flexo spasms were eliminated in the pa tient with the spinal cord injury an the patient with multiple sclerosis, a well as in 2 patients with spin bifida, in which flexor spasms wer a considerable problem.

In the ideal candidates, for whon the goal was to improve gait, severa important observations were noted All the patients were considerabl weaker after surgery than they wer thought to be before surgery. Th spasticity made them seem stronge Those who needed lateral suppor preoperatively continued to need i postoperatively. Patients showed dra matic improvements within the first months, with normalization of ton and increased range of motion. Be tween 6 months and 1 year, patient would plateau for about 6 month and, then, as muscle strength in creased, would make further gain and continuing progress during th entire length of available follow-up Gait pattern and speed were im proved in those patients who contin ued to need lateral support.

ig 2. Ages of patients at time of rhizotomy.



ONCLUSIONS

'he most recent series with the ›ngest follow-up has been reported y Peacock et al, who presented the esults of SPR on 60 children whose ges ranged between 20 months and 9 years and who were followed rom 1 through 5 years (20). These ıvestigators found that patients who ere most improved were purely pastic, intelligent, and more spastic ı the lower extremities than the upper extremities, had some forward lo-omotion, and were able to side sit ıdependently. Patients who were east improved were those with severe thetosis and marked contractures. ome of the unexpected postoperative ndings included improvements in eizure control, bladder control, and motional status.

The findings were similar in our eries, despite the shorter duration f follow-up. We observed, as othrs have reported anecdotally, that ıany patients showed improvement ı language and articulation skills as vell as in the fine motor skills of the pper extremities. The latter is robably related to an overall reuction in "noise" communicated hrough the spinal cord because ıany collaterals are disrupted when ootlets are sectioned.

While SPR has gained great favor ı the treatment of spasticity, several acts need to be remembered as we ontinue to perform the operation. irst, only a select group of patients vill gain from the operative procure. A strict selection protocol must e used in selecting candidates. Furthermore, the consideration of earlier surgery needs to be addressed. Patients who undergo surgery at an earlier age tend to do better. We are uncertain whether this is because of the plasticity of the nervous system or is a reflection of having to unlearn less abnormal movement patterns. Nevertheless, a case should be made for performing the operations earlier. Finally, the need for thorough preoperative and postoperative evaluation cannot be overemphasized. Because this procedure remains under scrutiny, we must continue to document the usefulness of the surgery, to further refine our selection process, and to optimize postoperative management.

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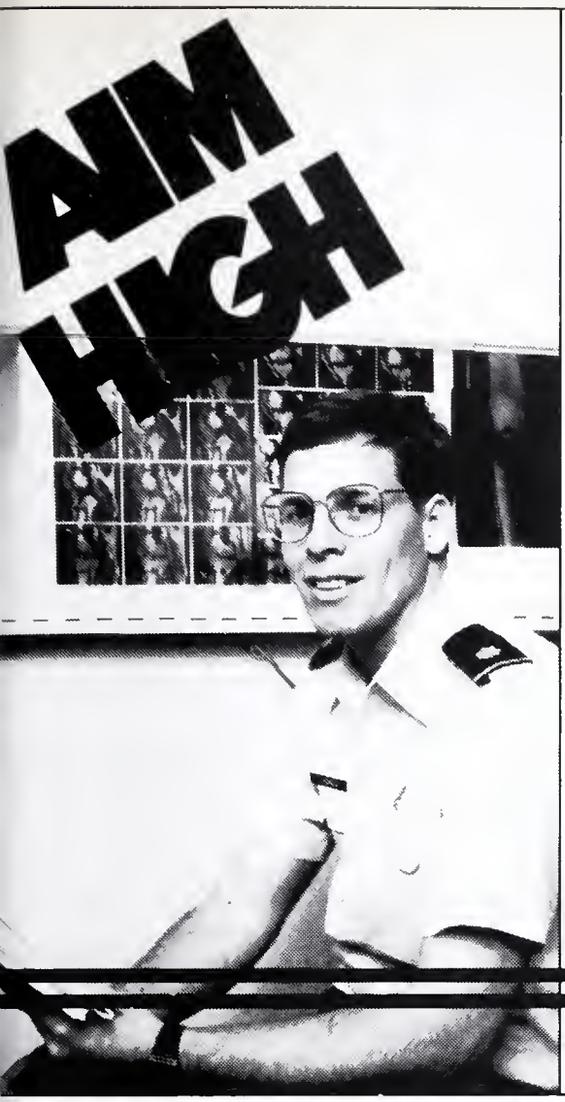

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Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request.

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Residency Director Position — The Memorial Hospital Family Practice Residency Program is seeking a board certified family physician for the position of Residency Program Director. The program, established in 1970, is community based and well respected. Appointment as faculty at The University of Texas Medical School at Houston (UTMSH) is included in position. Responsibilities include administration of the residency, liaison between UTMSH and Memorial Hospital, teaching residents, and direct patient care. Previous management and practice experience highly desirable. Salary commensurate with experience. Excellent benefits package. Send CV to Carol Paret, Memorial Healthcare System, Planning Department, 7737 Southwest Freeway, Suite 235, Houston, TX 77074. The University of Texas Health Center at Houston is an equal opportunity/affirmative action employer. Women and minorities are encouraged to apply.

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Rio Grande Valley — Three Family Physicians seeking Board Certified Family Physician to join their group. N obstetrics. Guaranteed income negotiable. If you hav tried solo practice and would like to have more tim with your family, contact J. Forrest Fitch, M.D., Valle Medical Arts Clinic, 5201 N. 10th, McAllen, TX 78504 512 631-5411.

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Dr. Aliza Lifshitz, Internist, Los Angeles, California, Member, American Medical Association

Patients come to physicians for many reasons. Beyond relief from pain, they seek compassion, empathy and support. AIDS patients receive all of these and more from Dr. Aliza Lifshitz.

Born and raised in Mexico and educated at one of Mexico City's finest medical schools, Dr. Lifshitz now serves the Hispanic community in Southern California. Over a third of her patients have tested HIV positive. Most live below the poverty level. Many are illegal aliens.

"I never forget what it means to be a doctor, and what it means is embodied in the Principles of Medical Ethics of the American Medical Association (AMA)," states Dr. Lifshitz.

You are invited to join Dr. Lifshitz and to join with her in her efforts to bring quality health care to those in need. Become a member of the American Medical Association today.

Members of the AMA are encouraged to join their state, county and specialty societies.

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CME / Continuing Education Directory

Courses

JULY

General Medicine

Jul 2–4, 1992
Highlights in Women's Health Care. Santa Fe, NM. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Jul 17–19, 1992
Caring for the Aging Population: Knowledge & Skills for the Primary Care Physician. San Francisco. Contact American Geriatrics Society, 770 Lexington Ave, Ste 300, New York, NY 10021 (212) 308-1414

Obstetrics and Gynecology

Jul 11–12, 1992
Transvaginal Surgery. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Jul 11–13, 1992
Issues in Care: Ob-Gyn. South Padre Island. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Jul 27–29, 1992
Ob-Gyn Summer Seminar. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Ophthalmology

Jul 24–25, 1992
PHACO 1992. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

AUGUST

Allergy

Aug 6–8, 1992
Clinical Allergy for the Practicing Physician. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Computer Applications

Aug 1, 1992
Getting Organized: Personal File Management. Austin. Contact Texas Medical Association Library, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1547

Family Medicine

Aug 6–9, 1992
Family Medicine Update. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Aug 13–15, 1992
Family Medicine in the Rockies. Copper Mountain, Colo. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Pathology

Aug 9–15, 1992
Fine Needle Biopsy Course. Mauna Lani, Hawaii. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Risk Management

Aug 15, 1992
Grand Rounds in Medical Malpractice. South Padre Island. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Aug 27, 1992
From Deposition to Courtroom Workshop. Houston. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411

SEPTEMBER

Cardiology

Sep 14–17, 1992
Clinical Electrophysiology: Cardiovascular Board Review. Philadelphia. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Dermatology

Sep 11–12, 1992
Wound Care: A Team Approach. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Internal Medicine

Sep 8–13, 1992
Intensive Review of Internal Medicine. Dallas. Contact The University of Texas Southwestern Medical Center, Office o CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Obstetrics and Gynecology

Sep 12–13, 1992
Transvaginal Sonography. Houston. Con tact Baylor College of Medicine, Office o CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Ophthalmology

Sep 10–12, 1992
Welsh Cataract Congress. Houston. Con tact Baylor College of Medicine, Office o CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Sep 10–13, 1992
Uveitis & Retinal Frontiers. Carmel, Calif Contact University of California at San Francisco, Extended Programs in Medica Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

Sep 18–19, 1992
Pediatric Advanced Life Support Provide Course. San Antonio. Contact The Univer sity of Texas Health Science Center, Offic of CME, 7703 Floyd Curl Dr, San Anto nio, TX 78284 (512) 567-4444

Psychiatry

Sep 24–27, 1992
Multiplicity of Approaches to Treatmen of Multiple Personality Disorder. Austin Contact Don Young, Shoal Creek Hospita 3501 Mills Ave, Austin, TX 78731 (512 452-0361

Risk Management

Sep 19, 1992
From Deposition to Courtroom. Austin Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-130 or (512) 370-1411

Sep 19–20, 1992
Grand Rounds in Medical Malpractice. E Paso. Contact Medical Risk Managemen Inc, 2500 City West Blvd, Ste 300, Hou ton, TX 77042 (713) 789-6518

Sep 24, 1992
Grand Rounds in Medical Malpractice. Lubbock. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

OCTOBER

Dermatology

Oct 17–18, 1992
The Skin from A to Z. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Oct 14–16, 1992
Experience in MDA-ALS Clinic. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Obstetrics and Gynecology

Oct 31–Nov 1, 1992
Transvaginal Sonography. Houston. Contact Department of Education, American Academy of Pediatrics, PO Box 927, Elk Grove Village, IL 60009-0927 (800) 433-9016

Oncology

Oct 10–13, 1992
Pharmacy Symposium on Cancer Chemotherapy. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Oct 17–23, 1992
Symposium on Fundamental Cancer Research. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Oct 20–23, 1992
Immunobiology of Cancer Research Symposium: Molecular and Cellular Mechanisms. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Ophthalmology

Oct 2, 1992
Cataract 1992. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Risk Management

Oct 1, 1992
Grand Rounds in Medical Malpractice. San Antonio. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Oct 3–4, 1992
Grand Rounds in Medical Malpractice. San Antonio. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Oct 8, 1992
Grand Rounds in Medical Malpractice. Dallas. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Oct 10, 1992
Grand Rounds in Medical Malpractice. New Orleans. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Oct 22, 1992
From Deposition to Courtroom. Dallas. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411

Oct 24–25, 1992
Grand Rounds in Medical Malpractice. Houston. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

NOVEMBER

Computer Applications

Nov 7, 1992
GRATEFUL MED: Computer Access to Information. Austin. Contact Texas Medical Association Library, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1547

General Medicine

Nov 21, 1992
Hyperlipidemia Seminar. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Oncology

Nov 6–10, 1992
International Symposium on Polyamines in Cancer. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Otolaryngology

Nov 5–7, 1992
Otolaryngology Update. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

Nov 5, 1992
Pediatric Advanced Life Support Renewal Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Nov 6–7, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Psychiatry

Nov 13–15, 1992
Group Therapy Symposium. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Risk Management

Nov 19, 1992
From Deposition to Courtroom. San Antonio. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411

Nov 21–22, 1992
Grand Rounds in Medical Malpractice. Dallas. Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

DECEMBER

Ophthalmology

Dec 10–11, 1992
Glaucoma Management. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Risk Management

Dec 5, 1992
Grand Rounds in Medical Malpractice. San Antonio. Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

JANUARY

Obstetrics and Gynecology

Jan 22–23, 1993
Breast Disease 1993. Houston. Contact The University of Texas Medical School at Houston, Office of CME, 1100 Holcombe Blvd, HMB 15.1509, Houston, TX 77030 (713) 792-5346

Risk Management Seminars

The following course is sponsored by the Texas Medical Association through its Practice Management Department. All seminars, unless otherwise announced, will be held from 7 pm–10 pm. For further information, contact the TMA Risk Management Office, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411.

Jun–Nov, 1992

From Deposition to Courtroom

Jun 11, Houston
Aug 27, Houston
Sep 19, Austin (during TMA Fall Leadership Conference)
Oct 22, Dallas
Nov 19, San Antonio

Calendar of Meetings

• Denotes Texas meeting

June

Jun 18–20, 1992, Austin
• Texas Medical Association 1992 CME Conference (for Planners and Sponsors of CME)
Contact TMA, 401 W 15th St, Austin, TX 78701 (800) 880-1300, Ext 1446 or (512) 370-1446

September

Sep 11–13, 1992, El Paso
• *Texas Society of Anesthesiologists Annual Meeting*
Contact TSA, 401 W 15th St, Ste 990, Austin, TX 78701 (512) 370-1659

Sep 19, 1992, Austin
• Texas Medical Association Fall Leadership Conference
Contact Jon Hornaday, 401 W 15th St, Austin 78701 (800) 880-1300 or (512) 370-1345

Sep 27–30, 1992, Houston
• *Texas Technology Transfer Association*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Sep 29–Oct 4, 1992, Quebec
American Society of Cytology Annual Scientific Meeting
Contact Yener S. Erozan, MD, 1015 Chestnut St, Ste 1518, Philadelphia, PA 19107 (215) 922-3880

October

Oct 31–Nov 4, 1992, Dallas
•*Pan American Medical Association Quincentenary Congress*
Contact PAMA, 3600 Gaston Ave, Ste 1051, Dallas, TX 75246 (214) 824-2087

November

Nov 18–21, 1992, Houston
• *American Association for Cancer Education*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

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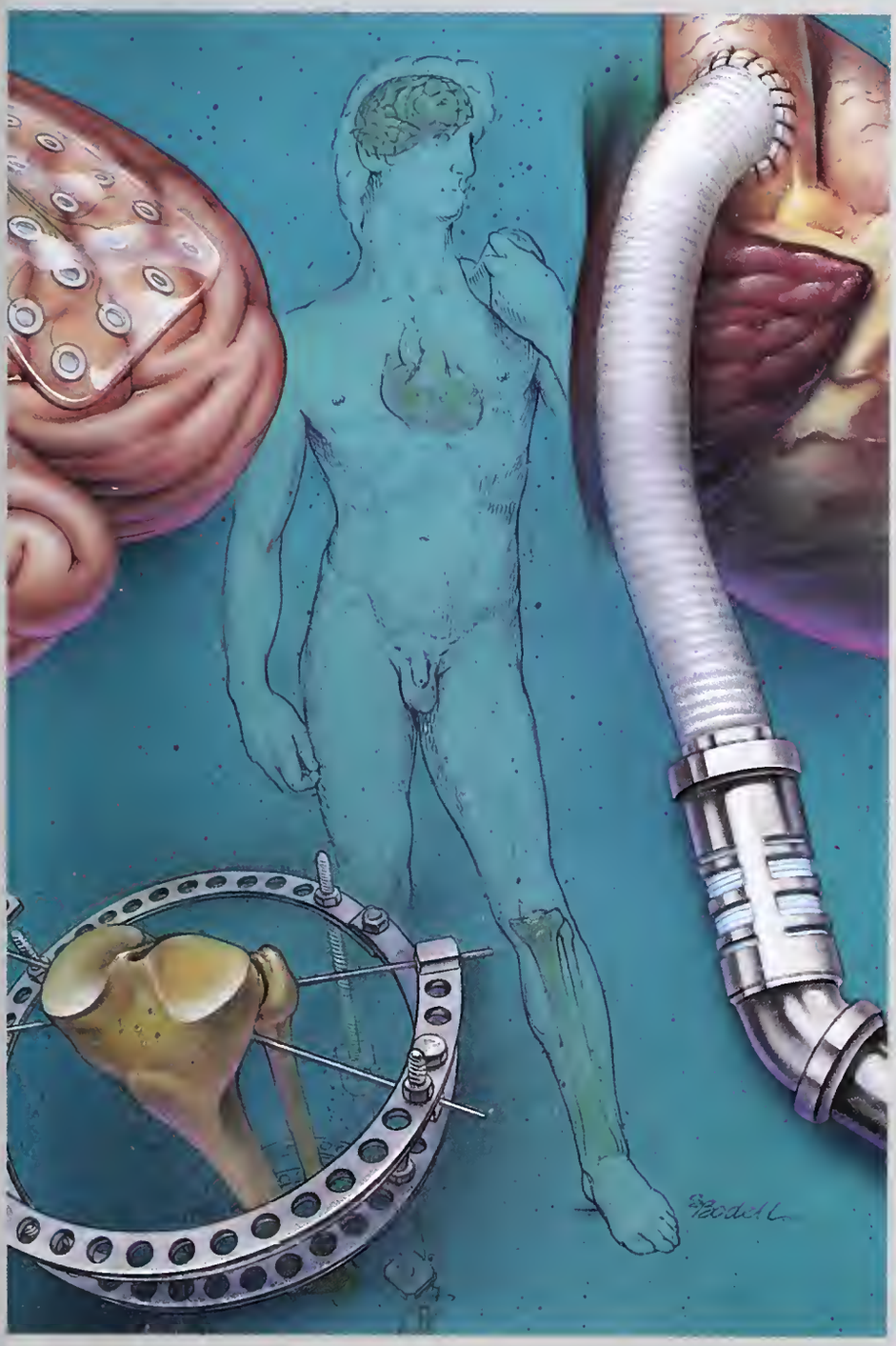

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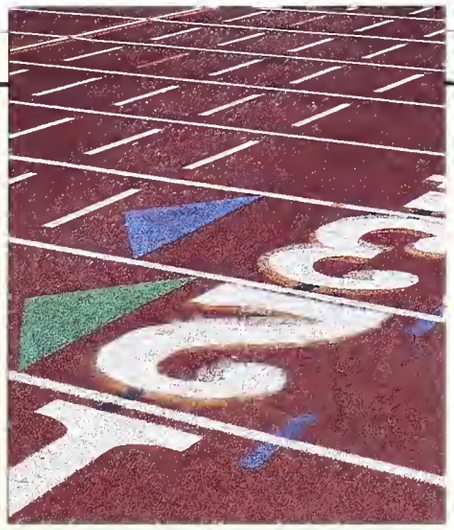

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Texas Medicine Feature

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"Sports medicine is one of the things I enjoy the most about my practice."

— Patricia Goen, MD

The breaks of the game: Sports medicine in Texas

From the big leagues to the sandlot to the jogging trail, sports medicine attracts physicians in many specialties.

BY LAURA J. ALBRECHT

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THE *Journal* of Texas Medicine

•••

OUTPATIENT-FOCUSED TREATMENT FOR CHILDHOOD DIABETES

•••

This approach may improve psychosocial adjustment and may result in short and long-term cost savings.

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Ensuring Quality--Managing Change

- ✓ Explore why physician leadership is essential to maintain quality patient care in these challenging, changing times from AMA President John L. Clowe, MD.
- ✓ Look at pending health-care legislation on Capitol Hill with invited guest U.S. Rep. J.J. "Jake" Pickle.
- ✓ Hear what direction the Texas Health Policy Task Force is taking from invited guest Gov. Ann Richards.
- ✓ Learn from M. Roy Schwarz, MD, AMA Senior Vice President of Medical Education and Science, about physician and patient fears of contracting HIV.
- ✓ Get an insider's look from Texas legislators at Sunset review of the Medical Practice Act and other medical issues facing the Texas Legislature.
- ✓ Discover ways to reduce hassles brought on by Medicare's resource-based relative value scale during a dawn duster session with Harold Whittington.
- ✓ Complimentary luncheon from Texas Medical Liability Trust.

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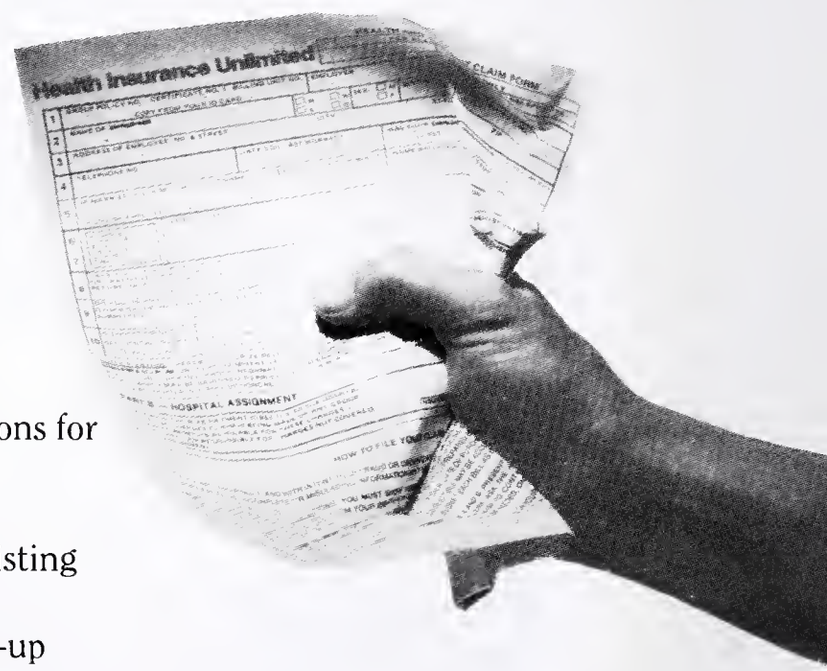

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Letters

Even inert chemicals in pesticides can cause harm

I AM WRITING TO COMMEND you on the excellent and timely article, "Environmental Encounters: What Primary Care Physicians Need to Know" (*Texas Medicine*, April 1992, pp 38–44).

Drs Bernard Goldstein and Ralph D. Morris made some good points about the need for physician awareness of environmental dangers that might be linked to patients' illnesses. Also, Dr Claudia S. Miller's book and her comments about multiple chemical sensitivity are most useful and very important.

However, I have to take issue with a piece of information about pesticides that is in the box on p 43. The problematic quote is: "Potential for injury from pesticides is based on toxicity of the active ingredient . . ." The *real* potential for injury is from the whole pesticide compound, which includes "inerts." But the term "inert" causes a false sense of safety, because to most people it means chemically or biologically inactive.

The "inerts" in a pesticide may consist of benzene, pentachlorophenol, xylene, carbon tetrachloride, formaldehyde, etc. In fact, when one of my patients was sprayed with Pounce, a pyrethroid, I found to my horror that 61.6% of the formulation consisted of xylene. He had central nervous system depression plus renal and hepatotoxic changes.

Please know that:

1. The label on any pesticide lists only active insect-controlling ingredients. Some pesticide formulations (like Tordon 2K pellets that contain 97% "inerts" and only 3% of the pesticide) demonstrate how much more information is needed on the labels. Regulation changes are emphatically encouraged.
2. The Environmental Protection Agency (EPA) does not know exactly what makes up any "inert" chemical, but allows registrants to market pesticides, and somewhat deceivingly so. My toxicology concern is that 55 chemicals categorized as "inerts" are significantly toxic as they are largely solvents. Many contain benzene rings, toxic metals, or halogenated hydrocarbons including petroleum compounds.
3. These "inerts" in pesticide formulations have been shown to cause cancer, nerve damage, and other chronic effects, as well as having adverse reproductive effects. In 1987, the EPA finally required manufacturers to include 60 inerts of "toxicological concern" on labels.
4. Inert ingredients pose special dangers to farm workers as well as special problems to health-care professionals who are attempting to treat cases of pesticide poisoning. Skin irritation and photosensitization may be caused by solvents and anticaking agents, including some methyl naphthalenes.
5. In 1986, severe dermatitis resembling a second-degree chemical burn affected 114 out of 198 farm workers employed in California orange groves that had been sprayed with the miticide, propargite. This poisoning incident was subsequently linked to a change in inert ingredients. Although the product, Omite-CR, was registered, a recent change in formulation decreased the rate at which the residue on the leaves disappeared, an attribute that had very serious implications for those working with this chemical. This was not recognized in the registration process, but was later confirmed by an epidemiologic investigation. Most manufacturers in the past have refused to reveal the names of such ingredients, claiming that they are trade secrets.

It is particulary important that those of us in medicine speak out against the errors in regulation that are no longer acceptable. We can work together to protect our patients, our environment, and our world.

Margaret R. Wells Diaz, MD, MPH
864 Central Blvd, Suite 100
Brownsville, TX 78520

Medicaid improvements worth notice

I WISH TO EXPRESS MY appreciation for the exciting changes that are taking place in the Texas Medicaid program secondary to the Texas Medical Association's negotiations with the Department of Human Services. [See "Medicaid RBRVS payment system begins April 1," *Texas Medicine*, April 1992, p 46.]

As a family physician Medicaid provider for the last 15 years, I have found the positive changes in the last couple of years remarkable. My office has seen a marked improvement in the rapidity with which claims are paid and has had little or no problem with claim rejection. Payment amounts for obstetrical care have become very reasonable; the unbundling of antenatal and delivery charges has helped make payment very fair. The biggest problems that remained were in reimburse-

ment for pediatric services and standard office visits, and, in my opinion, implementing the new fee schedule in April corrected this.

I am very hopeful that most if not all practitioners in Texas will now accept Medicaid patients. This could go a long way toward providing affordable care for all Texans. I appreciate that some physicians, however, are opposed in principle to government medical programs.

Certainly, under this new fee schedule, Medicaid is competing on a fair basis with commercial insurance, including HMOs, in attracting physician providers. If the Medicaid program remains economically viable, it should form a good basis for allowing the public and small businesses to buy into it, as envisaged by some of our national leaders, although it may take some time for physicians and the public to overcome their prejudices against the program.

I wish to congratulate the Texas Medical Association leaders and staff who have worked to get these changes implemented and let you know that you are truly appreciated.

H.N. Williston, MD
4201 Garth Rd, Suite 308
Baytown, TX 77521

Express your point of view in
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To submit a letter, send it to Texas Medicine, *TMA, 401 W 15th St, Austin 78701. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.*

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Please help TMA help your colleagues. Support the TMA Physician Health and Rehabilitation Assistance Fund. Your contribution is tax deductible.

If you would like to know more about how the fund assists indigent, impaired physicians, call TMA at (512)370-1342.

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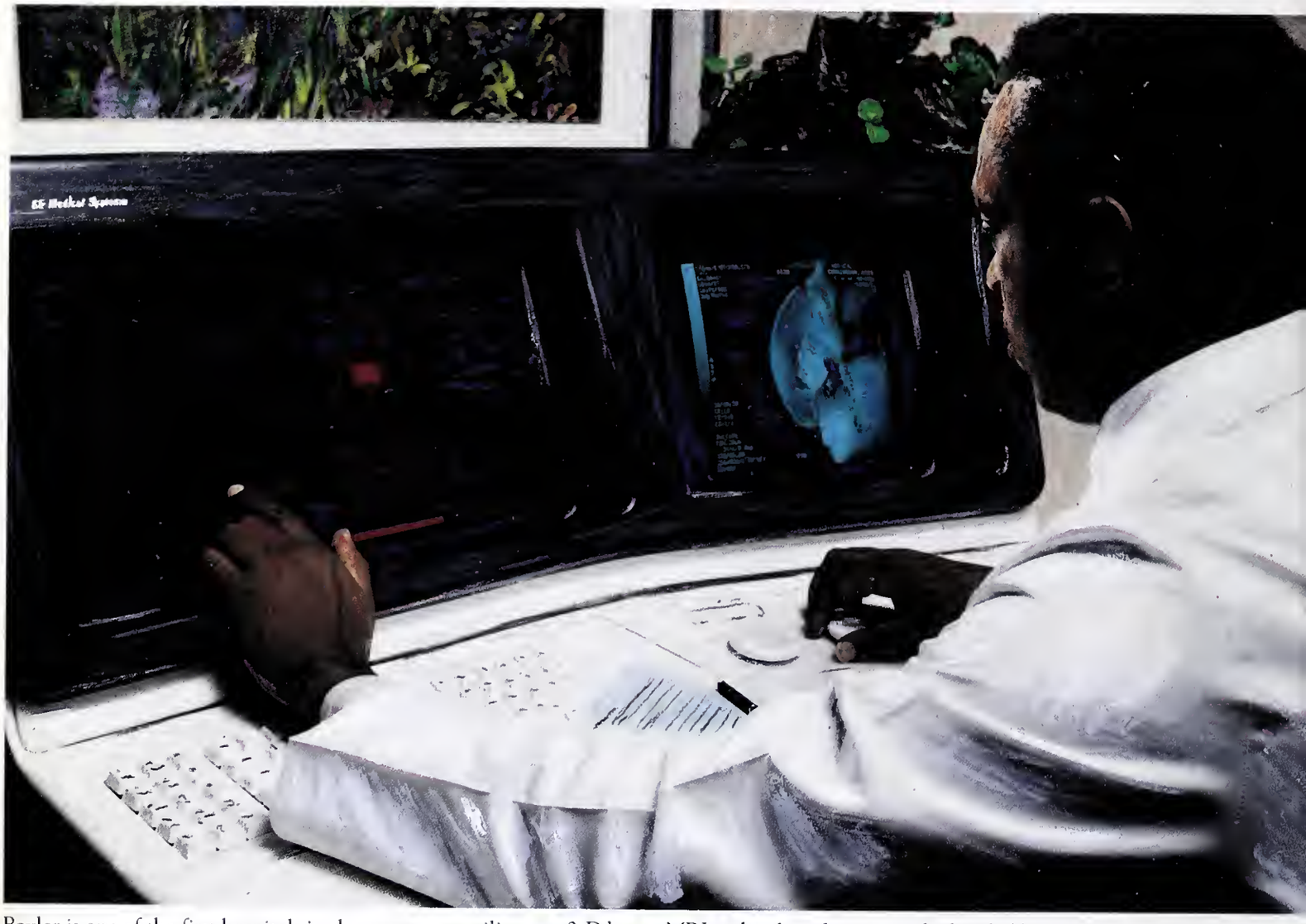

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Upfront

Dr Gamel urges physicians to fortify their profession

USING HIS PROXIMITY to the Alamo as a theme for a speech about medicine's need to defend itself against a host of adversaries, William G. Gamel, MD, was installed as Texas Medical Association president May 16 during TMA's Annual Session in San Antonio.

Promising to be "a tireless worker on your behalf," William G. Gamel, MD, starts his year as TMA president.

Speaking at the Annual Membership Luncheon, the Austin gastroenterologist urged physicians to fight complacency and apathy. "Unlike the defenders of the Alamo," he said, "medicine has the tools and resources to win — if enough of us join in the fight."

But, he admitted, "Our adversaries are getting smarter — employing the time-honored tactic of divide and conquer."

He reminded physicians of the need to keep patients as allies in the struggle to maintain quality care. "*We* are outnumbered," he said. "The people we care for are not. We must inspire and educate our membership to use their influence."

A TMA member since 1965, Dr Gamel is a former chairman of TMA's Council on Legislation. He also is an alternate delegate to the American Medical Association and a past president of Travis County Medical Society.

Dr Gamel graduated from The University of Texas Medical Branch at Galveston. Following his internship and residency at Parkland Memorial Hospital in Dallas, he began private practice in Austin in 1967.

Pointing out that medicine must be part of the effort to control medical costs, Dr Gamel said, "We are victims of our own success. The explosion in medical technology, drugs, and surgical capabilities carries a tremendous price. The American people must decide how much health care they want and how much they are willing to pay for."

But, he added, "We must see that cost-effective medicine is delivered. We must root out the abusers in the system — those who overtreat, over-aggressively turn to surgery, and demand exorbitant fees."

Government's wish for lower medical costs, however, must be balanced against the need for quality care, he said. "Like it or not, economics, politics, and public opinion are driving our future as much as medical science."

Dr Nixon sums up accomplishments of presidential year

"THERE LIES BEFORE THE medical profession of today a destiny compared with which all the glories of the past shall be eclipsed," quoted Sam A. Nixon, MD, Houston, in a speech to the Texas Medical Association House of Delegates as his term as TMA president ended in mid-May.

The quote is from a 1902 address by former TMA President Taylor Hudson, MD, said Dr Nixon, but it is fitting for today. "We indeed are standing 'in the brightening dawn of possibly the greatest epoch in the history of our calling,'" he told delegates.

But that epoch is not without its challenges. After describing TMA's impressive number of successes during the past year, Dr Nixon acknowledged that the hassles physicians face are still legion.

"Never in the history of medicine have physicians seen themselves so

Sam A. Nixon, MD, Houston, thanks delegates for their confidence, assistance, friendship, and hard work.

overwhelmed by government red tape and interference," he said.

"The government has forgotten, either deliberately or unintentionally, the original intent of the Medicare program. Its focus clearly has shifted from access to cost control."

But TMA is well equipped to help protect the medical profession, said Dr Nixon. "This association offers more hands-on services than any other state medical society in the nation and at the lowest dues payment of the ten largest societies."

Recalling his promise at the start of his presidential year to be guided by four words, Dr Nixon told delegates he had done his best to "communicate, cooperate, participate, and serve."

New TMA leaders take charge for 1992–1993

Robert M. Tenery Jr, MD, was victorious in a three-way race for Texas Medical Association president-elect. The Dallas ophthalmologist was elected by the TMA House of Delegates during its May meeting at Annual Session in San Antonio. The other candidates for president-elect were Frank Bryant, Jr, MD, San Antonio, and Margie B. Peschel, MD, Fort Worth.

In brief remarks to the delegates following his election, Dr Tenery referred to the fact that his father, Robert Mayo Tenery, MD, was a former TMA president: "I am both honored and pleased, but if he could be here today I know someone who'd be even more pleased than I am — in fact he stood on this very podium 30 years ago accepting this same honor. I'll never forget, he called me one night after I'd been in practice several years and said, 'Now it's time you gave back something to the profession that gave so much to you.'"

In nominating Dr Tenery as president-elect, former TMA President David Vanderpool, MD, Dallas, told delegates, "During this critical period, it is imperative for TMA to have a president who can represent us effectively to business and political leaders, as well as within our own profession. Rob is a leader in the truest sense of the word."

Dr Tenery, a third-generation Texas physician, has a distinguished record of leadership in organized medicine at the local, state, and national levels. He is past president of the Dallas County Medical Society and the Dallas Academy of Ophthalmology. Since 1979, he has served as a member of the TMA House of Delegates. In 1987, he was elected an alternate delegate to the AMA. He has chaired the TMA Membership Committee since 1985.

Others elected by the House included Betty P. Stephenson, MD, Houston, who was reelected to a 3-year term as secretary/treasurer. Mark J. Kubala, MD, Beaumont, and Bernard W. Palmer, MD, San Antonio, successfully sought reelection as speaker and vice speaker of the House, respectively.

Reelected to the Board of Trustees were Alan C. Baum, MD, Houston; J. Forrest Fitch, MD, McAllen; and Victor J. Weiss, Jr, MD, San Antonio. At its first meeting following the House session, the board reelected Dr Baum as chairman and Harold R. High, MD, Cuero, as vice chairman. Earl L. Grant, MD, Austin, was elected secretary of the board.

Robert M. Tenery, MD, Dallas, was elected TMA president-elect by the House of Delegates.

C.L. Montgomery, MD, Lubbock, was elected to fill a vacant seat as delegate to the AMA. In a five-way race, Phil H. Berry Jr, MD, Dallas, and Frederick L. Merian, MD, Yoakum, were elected as alternate delegates to the AMA. All other incumbent AMA delegates and alternate delegates eligible for reelection were elected.

Judy Tucker, MD, Dallas, and Russel Cravey, Temple, will serve 1-year terms as alternate delegates to the AMA from the Resident Physician Section and the Medical Student Section, respectively.

The House elected Raymond M. Hampton, MD, Pampa, to fill an open councilor seat in District 3. The councilors from districts 5, 6, 12, and 15 were reelected.

TMA bestows highest honor on Dr Mann

DESCRIBING JAMES C. MANN, Jr, MD, as someone who "has always in a quiet, dignified manner been able to pour oil on troubled waters and calm the seas," George Thannisch, MD, Lufkin, presented TMA's Distinguished Service Award to Dr Mann during the opening session of the House of Delegates in San Antonio in May.

The association's highest honor recognizes meritorious achievement in medical science, public service, and service to the profession and is designed to encourage others to attain these standards.

Dr Mann, a former chairman of the TMA Board of Councilors, is a general practitioner in Beaumont.

After telling delegates that "this is the greatest hour of my life," Dr Mann spoke about his involvement with organized medicine. He also urged his colleagues to help protect the environment of the earth.

"I think we are failing miserably in our stewardship (of the earth)," said Dr Mann. "How long can we play Russian roulette by pollution of our water and our atmosphere before the protective and sustaining environment of our beautiful home is destroyed? As the custodians of the health of our species, we must show more concern, more responsibility toward this exploding problem."

The award recipient also decried government interference in the medical profession and the deterioration of the family as the basic unit of society.

"Our society has deteriorated because our basic social unit has deteriorated," he said. "If we cannot rebuild a caring, disciplined, moral, loving family structure throughout our society, then we are doomed."

Dr Mann has served on many TMA committees and as a TMA delegate. He also was president of the Beaumont Academy of Medicine, president of the Tenth Medical District, and member of the board of trustees of Texas Medical Foundation. He served as chief of staff of Beaumont Municipal Hospital and as a member of many of its committees.

Dr Mann's teaching appointments include instructor of The University of Texas Medical Branch family practice residency program at St Mary's Hospital in Port Arthur and volunteer faculty at the Law Enforcement Academy at Lamar University.

Attending the award ceremony was Dr Mann's wife, the former Phyllis Louise Cole, and five of their six children.

George Thannisch, MD, Lufkin, left, presents TMA's Distinguished Service Award for 1992 to James C. Mann, Jr, MD, Beaumont.

Delegates recommend advance directives

ACTING IN RESPONSE TO A resolution from Bexar County Medical Society about the frequent use of full resuscitative efforts by emergency medical services personnel summoned by relatives of dying individuals who have expressed wishes not to be resuscitated, the TMA House of Delegates in May adopted an amended and one additional resolved, which were recommended by the Reference Committee on Financial and Organizational Affairs:

> That the Texas Medical Association encourage its members to educate patients, families, caregivers, and significant others in the necessity to have an appropriate, properly executed advance directive in a pre-hospital environment to protect the patient's wishes.
>
> That the Texas Medical Association encourage its members to educate patients, families, caregivers, and significant others in the appropriate use of emergency medical services in terminal situations.

In other action based on the report of the financial and organizational affairs reference committee, the House:

- referred back to the TMA Board of Trustees for further evaluation the issue of expanding the association's physician health and rehabilitation program by hiring either a trained counselor to assist county medical society and hospital medical staff impaired physician committees or a physician to be in charge of the program;

Texas delegation takes resolutions to AMA House

TEXAS PHYSICIANS HAVE A whole lot to say to their peers from around the country. From the meeting of the TMA House of Delegates in May came 23 resolutions — possibly a record number in Texas — calling for action at the American Medical Association level.

The resolutions, which ran the gamut from socioeconomic to medical education to legal to public health issues, were scheduled to be heard by the AMA House June 21–24. Action taken on the resolutions will be reported in subsequent issues of *Texas Medicine*.

- referred to the Hospital Medical Staff Section for study and report back in November a resolution that TMA develop a confidential consulting service to evaluate and help resolve problems with hospital medical staff members; and
- approved a recommendation that TMA support pay equity for all physicians in the uniformed services with adjustments upward for those on short-term mobilization assignments toward that received by those on extended tours and in the reserve component and regular services.

TMA House approves changes affecting delegation to AMA

IN A SERIES OF RELATED actions during its May meeting, the TMA House of Delegates addressed the length of service of delegates to the AMA, took the first step toward establishing the position of delegate emeritus to the AMA, and altered the bylaws about filling vacancies on the delegation.

Responding to a May 1991 request from the House to study means of determining the appropriate length of service for a Texas delegate to the AMA, the TMA Council on Constitution and Bylaws and the delegation proposed to the House that tenure, age, and retirement be addressed in the delegation's operating procedures and that the House approve those procedures.

The procedures establish a Delegate Review Committee that will evaluate the candidacy for reelection of all delegates who have served more than six terms, who will be past age 75 at the next election, or who, in the committee's judgment, are substantially retired from their usual activities in the profession of medicine. In these cases, the committee will counsel against seeking reelection unless the delegate is either a current member, a candidate, a potential candidate, or a recent member of an AMA board, council, or committee, or if the committee feels that the presence of that individual is of sufficient importance to the function of the delegation that an exception must be made.

The Reference Committee on Constitution and Bylaws heartily commended the council and delegation "for taking a hard look at very sensitive issues and responding with positive recommendations" and recommended approval of the council's proposal. The House concurred, following considerable discussion about a resolution that had called for specific limits to the number of terms of delegates to both the TMA and the AMA. That resolution was defeated in favor of the recommendations of the Council on Constitution and Bylaws.

In response to concerns about retaining the expertise and influence of some long-term delegation members who may not be eligible to remain on the delegation because of the new provisions discussed above, a recommendation to establish the position of delegate emeritus to the American Medical Association was approved by the House. A second vote, required because the proposed position requires a change to the TMA Constitution, will take place at the November meeting of the House.

The proposed amendment revises Article V, Section 2 of the TMA Constitution and Bylaws by deletion and addition as follows:

> Sec. 2. The membership of the House of Delegates shall consist of . . . and as nonvoting members: (14) the chairman of TEXPAC; ~~and~~ (15) other Past Presidents of the Association who are current active members; *and (16) delegates emeritus of the AMA Delegation.*

The House also amended bylaws so that AMA alternate delegate vacancies may be filled by House election at the next meeting of the House, rather than only during annual session as the bylaws had provided. The action also established that delegate vacancies should be filled either by election of the House or by presidential appointment of an alternate delegate.

Medical students select award winner

JOEL S. DUNNINGTON, MD, Houston, received the C. Frank Webber Award during a session of the House of Delegates in May. Dr Dunnington was recognized for his support of TMA's Medical Student Section (MSS).

The award is named for Dr Webber, whose leadership and dedication to medical students prompted the development of the student organization.

Dr Dunnington, assistant professor of radiology at The University of Texas M.D. Anderson Cancer Center, is noted for his work in cancer prevention and his vigorous campaigning against tobacco use.

While a student at The University of Texas Medical School at Houston, he coauthored the bylaws of the

Lester Peacock, Houston, right, presented the C. Frank Webber Award to Joel S. Dunnington, MD, on behalf of the TMA Medical Student Section.

MSS. As a resident, he served as chairman of the TMA Resident Physician Section and delegate to the TMA House. For the past 3 years, he has served as the TMA-MSS faculty advisor for UT-Houston.

Dr Dunnington is chairman of the TMA Tobacco Use Prevention Task Force and a member of the Council on Public Health. He is an alternate delegate to the TMA House from Harris County Medical Society and has served on a number of other TMA committees.

Young Physician Section presents 'Young at Heart' award

BETTY P. STEPHENSON, MD, Houston, was chosen by the TMA Young Physician Section (YPS) as the first recipient of its Young at Heart Award. She was recognized for her guidance and support of the TMA-YPS.

Dr Stephenson, an anesthesiologist, is secretary/treasurer of TMA. She is a former member and chair of the TMA Committee on Membership, an alternate delegate from Texas to the American Medical Association, and former president of the Harris County Medical Society.

The YPS will present the annual award to a doctor who no longer qualifies for membership in the YPS but who has gone out of his or her way to help support young physicians. A permanent plaque listing the award winners will hang in the TMA headquarters in Austin.

In presenting the award, Carolyn Evans, MD, Dallas, chair of the YPS, said, "Age by no means expresses what it means to be young or to be a young physician. Youth is a spirit which some are blessed to enjoy for a lifetime . . . . Dr Stephenson has always been there for us. We will never be able to repay her for her invaluable help, but we would like to give her this token of our esteem."

Betty P. Stephenson, MD, Houston, left, displays the Young at Heart award presented to her by Carolyn Evans, MD, Dallas, on behalf of the TMA Young Physician Section.

House confers honorary membership on 12 physicians

TWELVE TEXAS PHYSICIANS have been elected to honorary membership in the Texas Medical Association.

They are Billie L. Aronoff, MD, Dallas; Robert Bernstein, MD, Austin; Richard L. Berry, MD, Marshall; George H. Brandau, MD, Houston; J. Arch Coleman, MD, Waco; Thomas D. Cronin, MD, Houston.

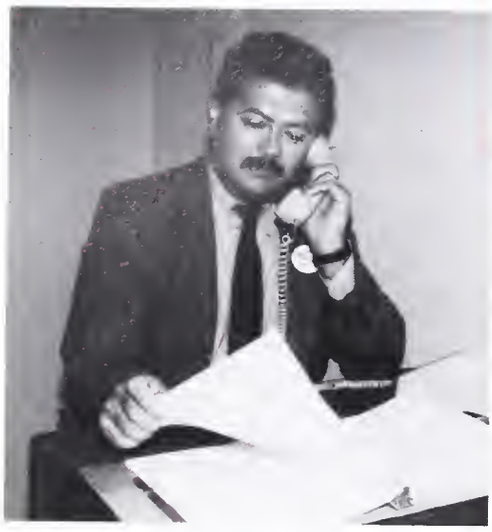
Also Thomas Graham Glass, Jr, MD, San Antonio; Coleman Jacobson, MD, Dallas; Samuel Newton Key, Jr, MD, Austin; John Kasper Kohlhaas, MD, Corpus Christi; Weldon Garrett Kolb, MD, La Marque; and John Lafayette Wright, Jr, MD, Big Lake.

Upon nomination by component county medical societies, the House of Delegates may elect to honorary membership those physician members "who have rendered outstanding service to organized medicine or made noteworthy contributions to scientific medicine and who have reached a point of comparative inactivity in the practice of medicine as determined by the county medical society."

Five physicians recognized for membership boost

WINNERS OF THE 1991 Texas Medical Association Outreach Program, which focused on recruiting and retaining members for the TMA and AMA, were honored at the TMA Annual Session in May.

TMA President William G.



Martin Guerrero, MD, San Antonio, telephones physicians as part of a membership drive. Dr Guerrero was one of the representatives from the Young Physician Section, which helped with the 1992 Annual Session Phonathon.

Gamel, MD, Austin, and Harris M. Hauser, MD, Houston, recruited the most members for the AMA and TMA, respectively. Drs Gamel and Hauser participated in the "peer-to-peer" program, in which physicians contact prospective members.

In the TMA phonathon program, which targets members who have not renewed TMA or AMA dues, William H. Reading, MD, Round Rock, recruited the most members for TMA. TMA Board of Trustee member Byron L. Howard, MD, Dallas, and Ted Forsythe, MD, Lubbock, tied in recruiting the most AMA members.

The phonathon and peer-to-peer programs for 1992 were launched during Annual Session. If you can help with the peer-to-peer program, contact Amy Bruno, TMA membership department, (800) 880-1300, ext 1443.

Journal section focuses on clinically useful scientific articles

EACH MONTH, *TEXAS MEDICINE* publishes in its Journal section a small number of carefully selected scientific articles. In addition to clarity, accuracy, and general high quality, articles are chosen for their clinical usefulness to a wide assortment of Texas physicians.

Articles are reviewed in a two-step process, which begins with selecting manuscripts with topics appropriate to *Texas Medicine*. Those articles selected for full peer review are reviewed by consultant specialists and an editorial committee. Reviews usually take 10 to 12 weeks.

Authors interested in submitting articles for upcoming Journal sections should consult the instructions on p 20. For further information, contact Kathryn Trombatore, managing editor, *Texas Medicine*, (800) 880-1300, ext 1380, or (512) 370-1380.

TMA Auxiliary grows into TMA Alliance

MEETING FOR ITS 74TH Annual Session, the TMA Auxiliary's House of Delegates voted overwhelmingly to change the organization's name to the Texas Medical Association Alliance. The Texas group is the first in the nation to effect this change, although it is being considered by several other states and was scheduled to be voted on by the AMA Auxiliary's House of Delegates in June.

Texas also has the first county auxiliary to change its name; Grayson County voted a change to the Grayson County Medical Society Alliance earlier this year.

The name change is the result of a yearlong study by an image development committee chaired by Mary Lynn Smith of Athens.

In addition to the new name, delegates adopted a new logo and a new slogan, "Physicians' Spouses Joining to Care."

Officers for 1992–1993 installed during the San Antonio convention are: Barbara Williams, Lake Jackson, president; Linda Alexander, Smith County, president-elect; Mertie Wood, Bexar County, first vice president; Sandy Currie, Potter-Randall Counties, western regional vice president; Cathy Powell, Travis County, southern regional vice president; Annette Domingue, Angelina County, eastern regional vice president; Susie Tonymon, Tarrant County, northern regional vice president; Margene Beckham, Travis County, treasurer; Terri Tubbs, El Paso County, recording secretary; Mary Meyers, Brazoria County, corresponding secretary; and Dixie Louis, Galveston County, parliamentarian.

A new award, begun by 1991–1992 TMA Alliance President Cyndy Hudgins, honors the county chapter with the best over-all celebration of Healthier Youth 2000, which centers around an April 1 "Don't Fool Around with Your Health" event. The winner this first year was Smith County, whose president, Marsha Harrison, center, is pictured with TMAA President Cyndy Hudgins, left, and AMAA President Sherry Strebel. Smith County also won the Bright Idea award for its "Down the Drain" environmental protection project.

A LEGACY OF CARING SAYS THANKS

CHAIRMAN OF THE TMA BOARD OF TRUSTEES Alan C. Baum, MD, Houston, right, presents a plaque to former TMA President Max C. Butler, MD, Houston, in recognition of Dr Butler's role in establishing A Legacy of Caring endowment fund for the TMA Education and Research Foundation. Dr Butler, who was recognized during the House of Delegates meeting May 14 in San Antonio, has chaired the state campaign committee since 1990.

The endowment, which will support public health and medical information and education programs that have the highest opportunity for improving the health of Texans, has more than doubled its initial $2 million goal. Dr Butler reported that the campaign stood at $4,628,845.02 as of May 14 and that the first proceeds from investing the endowment have been earmarked for a project in El Paso (see story on p 28.)

TMA staff members hit milestones

LOYALTY TO THEIR JOB IS A trademark common to many staff members at Texas Medical Association. In the first half of 1992, four long-time TMA employees were recognized.

- Amy Wilson, executive director of the TMA Alliance (formerly TMA Auxiliary), observed her 20-year anniversary with the association April 1.
- Becky Ellis, who served as former TMA Executive Director C. Lincoln Williston's executive assistant until his retirement in 1986 and whose duties since then included assisting with the TMA Board of Trustees, retired March 31. Ms Ellis had worked for TMA since 1972.
- Doris Nowlin, one of the two original employees of the Texas Medical Association Insurance Trust and most recently administrative manager, retired at the end of May. Ms Nowlin joined TMAIT in 1956.
- Owens Williams retired at the end of 1991. A 28-year employee, Mr Williams provided janitorial services to the association. ★

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Material for the Journal Section of *Texas Medicine* may be sent to the Managing Editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701. It must be offered solely to this journal. *Texas Medicine* seeks high quality educational articles, written to appeal to a broad range of Texas physicians. When possible, authors are encouraged to consider submitting "brief report" format articles of from 1,200 to 1,500 words. Articles are screened for appropriateness for *Texas Medicine*. Those selected for peer-review are reviewed by consultant specialists and an Editorial Committee, and accepted or rejected on the basis of individual merit, appropriateness, and the availability of other material. Reviews usually take 10 to 12 weeks. *Texas Medicine* reserves the right to reject up to press time any articles that may have been accepted for publication.

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Transmittal letters not containing the foregoing language signed by all authors of the manuscript will necessitate return of the manuscript.

JOURNAL ARTICLES

Manuscripts should be typed double-spaced with ample margins. Three copies, including illustrations, should be submitted and the author should keep a copy.

Titles should include the words most suitable for indexing the article in "Index Medicus," should stress the main point, and should be brief.

Include a mailing address and telephone number for each author.

An introductory summary of 100–150 words is required.

Text should be narrative with complete sentences, few abbreviations, and logical subheadings. For spelling and usage the editors follow "Dorland's Illustrated Medical Dictionary," 26th edition, and "Webster's Third New International Dictionary, Unabridged."

The text of observational and experimental articles is usually — but not necessarily — divided into sections with the headings: Introduction, Methods, Results, and Discussion. Subheadings may be needed to clarify content. Other types of articles may need different formats.

When citing clinical laboratory data, please report in Systeme International (SI) units.

For more extensive information about preparing medical articles for publication, the editors suggest the following sources:

International Committee of Medical Journal Editors: Uniform requirements for manuscripts submitted to biomedical journals. The complete document is available in the June 1982 issue of the *Annals of Internal Medicine*.

Iverson C, Dan BB, Glitman P, et al: The American Medical Association Manual of Style, ed 8. Baltimore, Williams & Wilkins, 1989.

CBE Style Manual Committee: CBE style manual: a guide for authors, editors, and publishers in the biological sciences, ed 5, rev and expanded. Bethesda, Md, Council of Biology Editors, Inc, 1983.

In addition, many excellent books and manuals are devoted to principles and techniques of clear, concise writing, which are applicable to scientific as well as general topics.

REFERENCES

References to scientific publications should be listed in numerical order at the end of the article, with reference numbers placed in parentheses at appropriate points in text.

Minimum acceptable data:

Journals: Authors, article title, journal, volume, inclusive pages, year.

Books: Author, title, place of publication, publisher, year.

Other sources: Enough information must be included so that the information can be identified and retrieved.

Letters, personal communications, and sources not readily available should be excluded from the reference list, but may be mentioned parenthetically or in footnotes.

ILLUSTRATIONS

Illustrations should be black and white drawings or positive photographs, with neat, uniform, fairly large lettering. A label pasted to the back of each illustration should indicate its number, topic, author's name, and title of article in brief.

Legends should be in complete sentences, numbered, and typed on a separate sheet of paper.

Tables should be typed on separate sheets. Column headings should show points of similarity; side headings, points of difference.

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Editorial commentary should be written in clear, concise language. Length should be about two or three pages typed with double spacing. Commentary will be published in the appropriate section at the discretion of the managing editor and editorial advisors.

Letters

Letters will be published at the discretion of the managing editor and editorial advisors. Length should be fewer than 400 words. A few references, preferably less than five, may be included. All letters are subject to editing and abridgment.

News

News items should be sent to *Texas Medicine*, Texas Medical Association, 401 W 15th St, Austin, TX 78701.

Obituaries

Listings of deceased TMA members are published when adequate information is received.

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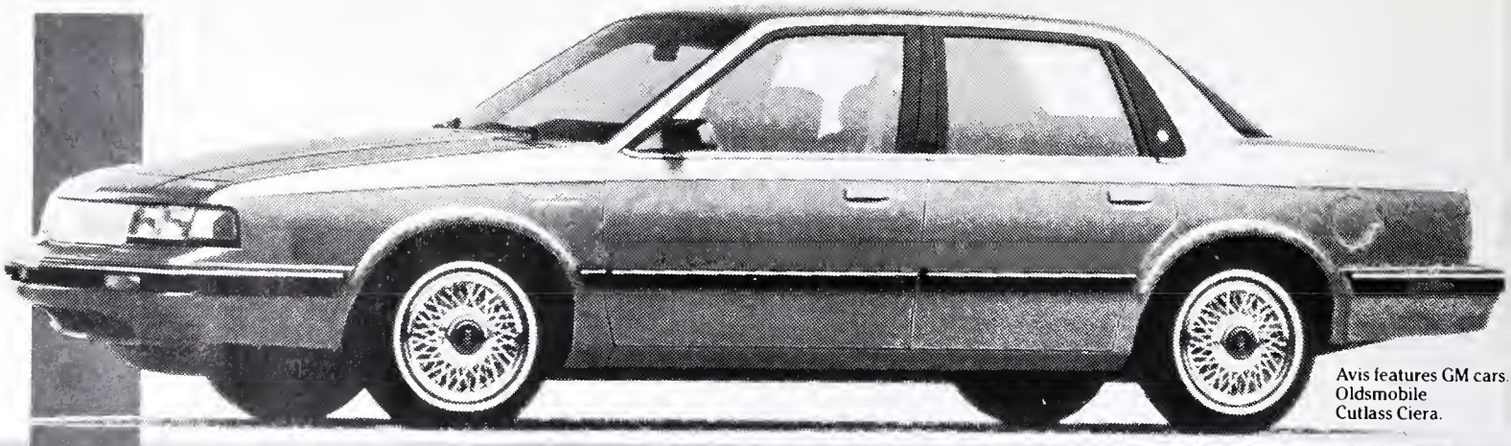

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People

NEWSMAKERS

Parnell Avery, MD, Houston general surgeon, was installed as president of the American Society of Abdominal Surgeons.

The Houston Surgical Society selected plastic surgeon **Raymond O. Brauer, MD,** as the Distinguished Houston Surgeon for 1992.

Raymond O. Brauer, MD

Snyder family practitioner **Nelson Brice, MD,** has been elected president of the Colorado Basin Medical Society.

Lieutenant Governor Bob Bullock appointed neurologist **Rachelle Smith Doody, MD,** to the Texas Council on Alzheimer's Disease and Related Disorders. Dr Doody directs the Alzheimer's Clinic at Baylor College of Medicine.

Please let *Texas Medicine* know about your honors and achievements.

Criteria for inclusion in the Newsmakers section are: TMA member; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, Texas Medicine, *401 W 15th St, Austin, TX 78701.*

Stanley Feld, MD, was elected vice president of the American Association of Clinical Endocrinologists.

Tracy Gordy, MD, medical director of Shoal Creek Hospital in Austin, was inducted into the National Academies of Practice, a national interdisciplinary health policy forum.

Thomas S. Harle, MD, professor of radiology and associate vice president for academic affairs at The University of Texas M.D. Anderson Cancer Center, was installed as president of the Texas Radiological Society. Other elected officers include **Dale B. Brannom, MD,** Abilene, president-elect; **Stewart R. Reuter, MD,** San Antonio, first vice president; **Helen C. Redman, MD,** Dallas, second vice president; **Ted L. Carelock, MD,** Plano, secretary; and **Leslie L. Lemak, MD,** Houston, treasurer.

Thomas S. Harle, MD

Vernon Knight, MD, professor of biotechnology, microbiology, immunology, and medicine, has been appointed director of Baylor College of Medicine's Center for Biotechnology.

Malcolm L. Mazow, MD, is the first recipient of the Walter and Ruth Sterling Professorship in Ophthalmology at The University of Texas Medical School at Houston.

Walter J. Meyer III, MD, was appointed to the Gladys Kempner and R. Lee Kempner Professorship in Child Psychiatry. Dr Meyer is the vice dean for the School of Medicine and professor of psychiatry and behavior sciences at The University of Texas Medical Branch at Galveston.

Bert W. O'Malley, MD, cell biology department chairman at Baylor College of Medicine, was elected to membership in the National Academy of Sciences.

Jack A. Roth, MD, chairman of the thoracic surgery department at The University of Texas M.D. Anderson Cancer Center, received the Lucy Wortham James Award from the Society of Surgical Oncology. Dr Roth was recognized with the society's highest honor for his exceptional contributions in clinical oncology research.

Chief of the breast surgical section at The University of Texas M.D. Anderson Cancer Center, **Eva Singletary, MD,** was chosen for the special commission on breast cancer, a division of President Bush's cancer panel. The commission will examine the status of breast cancer research, prevention, and treatment in the United States. The panel also will draft a proposal of ways to decrease breast cancer mortality.

OBITUARIES

John Walker Armstead, Jr, MD, 65; Dallas; Meharry Medical College, 1954; died April 2, 1992.

Vasireddy Babu, MD, 44; Odessa; Gunter Medical College, India, 1969; died April 6, 1992.

Correction

John Stuart Scott, DO, Temple, was reported deceased in the June 1992 issue of *Texas Medicine*. Dr Scott is alive and well and currently associate professor of anesthesia and chronic pain at Scott & White Memorial Hospital and Texas A&M University Health Science Center. The editors of *Texas Medicine* deeply regret the error and extend best wishes for continued good health to Dr Scott.

Paul James Edmondson, MD, 70; Odessa; University of Tennessee Center for Health Science, 1946; died April 7, 1992.

N. Maxwell Goodloe, MD, 81; Houston; University of Virginia Medical School, 1939; died April 20, 1992.

Edwin H. Gray, MD, 71; Austin; Medical College of Virginia of Virginia Commonwealth University, 1949; died May 3, 1992.

Thomas Francis Hogan, Jr, MD, 65; San Antonio; University of Pennsylvania School of Medicine, 1950; died November 19, 1991.

Paul H. Mitchell, MD, 78; Austin; University of Arkansas School of Medicine, 1941; died April 13, 1992.

John M. Prine, MD, 64; Arlington; The University of Texas Medical Branch at Galveston, 1952; died May 5, 1992.

Benjamin V. Salazar, MD, 49; Amarillo; University of Copenhagen, 1965; reported deceased.

Jeffrey Scott Wilson, MD, 37; Dallas; The University of Texas Southwestern Medical School, 1980; died April 17, 1992.

Eduardo T. Ximenes, MD, 77; San Antonio; The University of Texas Medical Branch at Galveston, 1941; died April 27, 1992.

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Public Health

Delegates confront gun control, abortion

ABORTION AND GUN CONTROL. From the confines of the Reference Committee on Public Health and Scientific Affairs to the floor of the House of Delegates, these two emotionally charged issues drew comments, both pro and con, from physicians during the 125th Annual Session of the Texas Medical Association in May in San Antonio.

When all was said and done, delegates voted to refer the subject of effective gun control to the Council on Legislation for study with a report due to the House in November. A resolution opposing abortion on demand was defeated and the current TMA policy statement was reaffirmed.

The resolution on gun control, submitted by the Dallas County Medical Society, called for TMA to "strongly support effective gun control legislation in Texas." Some physicians arguing against the resolution questioned the vagueness of the term "effective gun control." Others voiced concern about violating constitutional rights. Doctors speaking in favor of gun control based their views on trauma costs, children's injuries and deaths from gunshot wounds, and adult mortality.

The abortion resolution from Eastland-Callahan-Stephens-Shackelford-Throckmorton County Medical Society called for the TMA to oppose the procedure except in cases of incest, rape, endangerment to the life of the mother, or in the case of a gross fetal anomaly. Testimony heard by the reference committee dealt with concerns about the health impact of improperly performed abortions and the welfare of the fetus.

Current policy on abortion states, "Association guidelines for performance of abortion are based upon early and accurate diagnosis of pregnancy; informed and nonjudgmental counseling; prompt referral; skillful and understanding personnel working in a good facility; reasonable cost; and professional follow-up."

In a related issue, the House referred to the Council on Scientific Affairs a resolution opposing the use of fetal tissue from induced abortions in research.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

TMA House tackles public health issues

FROM BREAST IMPLANTS to family violence to counseling of HIV-infected physicians, the TMA House of Delegates acted on a multitude of public health issues during Annual Session in May.

Concerning breast implants, the House recommended that due to insufficient data to merit a ban on silicone gel breast implants, additional clinical trials should be conducted. The delegates affirmed that the decision for implant surgery should rest with an informed patient and her physician and should not be restricted to certain categories of indications pending results of clinical trials. They also called for physicians to keep patients informed of the risks and benefits of breast reconstructive surgery and they supported the establishment of a breast implant registry. A report from the Council on Communication was referred back to the Council on Public Health because of a concern that more data are needed before TMA can support removal of implants from all affected patients.

In other public health action, the delegates:

- Recommended the Ad Hoc Inter-Council Committee on AIDS, in consultation with the Council on Public Health, appoint a panel of consultants to advise local communities who wish to establish an expert review panel as called for by HB 7.
- Recommended the Council on Legislation review and seek an amendment to HB 7 concerning HIV-positive physicians due to current science and revisions in CDC guidelines concerning exposure-prone procedures. Delegates also approved TMA preparation of guidelines based on a pluralistic approach to be distributed to physicians and county medical societies.
- Commended the Texas Medical Association Insurance Trust for its leadership in adopting a policy of recognizing HIV infection in health-care providers as evidence of disability. Approved with referral to the Council on Legislation that TMA work with other disability carriers to persuade them to voluntarily adopt similar policies and that, if voluntary action is unsuccessful, TMA seek legislative action to make such policies mandatory.
- Adopted a policy on mammography: Centers offering mammography should conform to the guidelines of the American College of Radiology and encompass the ensuing criteria: (a) mammography should be performed in a facility under the direct supervision of a radiologist who is certified by the American Board of Radiology or who has completed a radiology

AGENDA ON AIDS

It's IDU, not IVDU

The term "intravenous drug user" (IVDU) has been used since the onset of the AIDS epidemic to describe individuals who share equipment for intravenous injection of drugs and are at risk of HIV infection. The Centers for Disease Control has now adopted the terms "injecting drug user" (IDU) and "drug injector" to describe individuals at risk who inject nonintravenously as well as intravenously. The term was developed by the CDC when interviews with persons with AIDS and HIV infection revealed that some were infected through nonintravenous injection of drugs.

How likely is it that a patient with a positive HIV test is not really infected?

The recommended laboratory procedure is to first perform an ELISA test on the blood sample. If this is positive, then the ELISA is repeated on the same sample. If it is again positive, then a confirmatory test (called western blot) is done on the same specimen. If it is positive, then the patient is considered to be infected with HIV. Using this sequence, a competent laboratory would expect to have a false positive fewer than 7 times per million specimens. Physicians should make certain that the laboratories they employ use this sequence. Using less than this three-step procedure can increase the rate of false positives by several orders of magnitude. The legal, social, and psychological implications can be profound.

Richard M. Grimes, PhD, director of the AIDS Regional Education and Training Centers for Texas and Oklahoma at The University of Texas at Houston School of Public Health, will provide answers about AIDS each month in this column. For further information about this topic or any HIV topic, call the AIDS Helpline for Health Professionals at (800) 548-4659.

residency approved by the Accreditation Council for Graduate Medical Education or American Osteopathic Association; (b) mammography should be performed only on dedicated equipment that provides an adequate device for breast compression; (c) the mammography unit should be calibrated by a qualified radiation physicist at the time of installation and at least annually; and (d) an adequate quality assurance program should be in place. Any person or persons interpreting the results of a mammography procedure should have the following minimal qualifications: (a) be a licensed physician in the State of Texas; (b) have certification by the American Board of Radiology or have completed a radiology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association; and (c) have demonstrated competency in the interpretation of mammograms.

- Recommended that TMA sponsor a panel discussion on family violence law and legal responsibility at the 1992 Fall Leadership Conference and a general session on family violence at the 1993 Annual Session. It also was recommended that family violence be included as a funding project for A Legacy of Caring, the endowment fund of the Texas Medical Association Education and Research Foundation.
- Recommended that county and state medical societies and the American Medical Association assist the Centers for Disease Control in collecting data on the level and extent of tobacco education. The House also approved a resolution encouraging physicians to receive formal training in smoking cessation and prevention and to use these techniques in their daily practices.
- Called for TMA to pursue appropriate methods to seek a stay of implementation of the OSHA bloodborne pathogen standard pending review and revision of the standard where appropriate and ask the American Medical Association to enter into dialogue with OSHA to review the regulations and their applicability/adaptability to the schedule of fines, which appear excessive for the physician's office.
- Approved and referred to the Council on Legislation a resolution supporting the Texas Department of Mental Health and Mental Retardation as the sole licensing agency for psychiatric hospitals in Texas.
- Referred to the Council on Legislation support for establishing an Office of Minority Health under the direction of the Texas Department of Health and encouraging the legislature to provide funding for the office during the 1993 session.
- In matters of public safety, the House approved with referral to the Council on Legislature that TMA support legislation requiring truck trailer manufacturers to install 22-inch underride safety guards on all new tractor trailers, support legislation to require approved bicycle helmets, and endorse the use of vapor recovery technology at gasoline stations to reduce gasoline fumes.
- Approved and referred to the Council on Legislation a recommendation that TMA meet with attorneys to develop guidelines to resolve liability issues involving immunizations. The recommendation also requests the AMA to seek federal legislation to designate immunizations a matter of universal entitlement and to increase appropriations accordingly.

A Legacy of Caring funds border health pilot program

EDUCATING WOMEN IN BORDER *colonias* near El Paso about cholera, immunizations, cervical cancer, and diabetes will be the focus of the first pilot program funded by the A Legacy of Caring endowment fund of the Texas Medical Association Education and Research Foundation (TMA-ERF).

The TMA Board of Trustees voted May 13 to award $10,000 to the Adopt-A-Neighborhood program, a cooperative effort between the TMA Alliance (formerly TMA Auxiliary) and the El Paso City-County Health Department. The city-county health department will train TMA Alliance volunteers to serve as mentors to women in the *colonias*.

"The El Paso City-County Health Department is particularly pleased to have been chosen by TMA to assist in delivering public health educational materials to high-risk groups in our *colonias*," says Laurance N. Nickey, MD, director of the department. "We are absolutely thrilled with this partnership between the private sector of medicine and a local public health organization."

Details of the project were unveiled May 27 during a meeting of the board of the El Paso City-County Health Department. The project's objectives are to provide short-term solutions to immediate health problems in the *colonias* through health promotion activities; to provide a resource to address emergency situations in the border areas, such as the current cholera threat; and to establish the foundation for long-term solutions to border health problems.

"Improving public health along the US-Mexico border has been a TMA priority since we initiated the first four-state Border Health Conference in 1989," says Alan C. Baum, MD, chairman of the TMA board. "That is why we are extremely pleased to award the first grant from the A Legacy of Caring endowment to the Adopt-A-Neighborhood program."

TMA-ERF launched the A Legacy of Caring endowment fund with a statewide fundraising campaign in 1990. The initial goal was to raise $2 million for a permanent endowment. Texas physicians have already contributed $4.9 million. Interest income from the endowment fund will be used to finance TMA-sponsored programs in public health and medical education and information. ★

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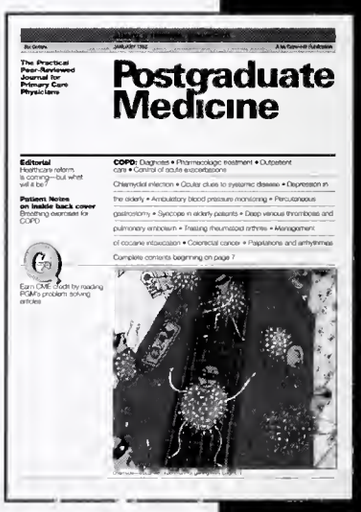

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Law

July 6 deadline for compliance with all provisions of OSHA regs

The final installment of Texas Medicine*'s series on the new OSHA Bloodborne Pathogen Standard focuses on provisions that go into effect July 6, 1992. Jane Matheson, JD, a partner with the Austin law firm of Hughes & Luce, LLP, and former deputy assistant secretary of labor for OSHA, provided a general overview of those provisions. Previous articles in the May 1992 and June 1992 issues of* Texas Medicine *dealt primarily with general requirements of the standard such as the development and implementation of an exposure control plan and a training and recordkeeping program.*

THE PROVISIONS OF THE standard that go into effect July 6 focus almost exclusively on the specific rules a physician/employer is required to follow to protect his or her employees from occupational exposure to bloodborne pathogens. The areas covered by these provisions include hepatitis B vaccinations, required labeling, housekeeping procedures, availability and use of personal protective equipment, procedures for handling contaminated sharps and other regulated wastes, and protocols for post-exposure evaluation and follow-up.

"These provisions constitute the nitty-gritty details of the standard," says Jane Matheson, JD. "They will have a direct effect upon the day-to-day operations of all physician/employers covered by the standard. Disposal practices for seemingly mundane items such as tongue depressors and paper covers on examining room tables will need to be reviewed."

Ms Matheson also emphasized that the standard requires a physician/employer to be in full compliance with all provisions of the standard by July 6, 1992, and that based upon published reports of recent OSHA citations, the standard will be enforced.

Physician/employers should also bear in mind that an OSHA inspection may not be limited to compliance with the bloodborne pathogen standard, but may encompass other OSHA regulations as well. As in all legal issues, physicians should consult their own attorneys on specific areas of concern.

Work practice controls

The OSHA standard defines a work practice control as a control that reduces the likelihood of exposure by altering the manner in which a task is performed.

Examples of work practice controls set forth in the standard include:

- requiring employees to wash their hands following removal of gloves and other personal protective equipment and following contact with blood or other potentially infectious materials;
- prohibiting contaminated needles and other contaminated sharps from being recapped or removed unless the physician/employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure, and requiring such recapping or removal to be accomplished only through the use of a mechanical device or a one-handed technique;
- prohibiting the shearing or breaking of contaminated needles;
- prohibiting activities such as eating, drinking, smoking, applying cosmetics, or handling contact lenses in any work area where there is a reasonable likelihood of occupational exposure;
- prohibiting food and drink from being kept in places or areas where blood or other potentially infectious materials are present;
- requiring all procedures involving blood or other potentially infectious materials to be performed in such a manner as to minimize splashing, spraying, spattering, and the generation of droplets; and
- prohibiting mouth pipetting or the suctioning of blood or other potentially infectious materials.

A physician/employer is required to ensure that employees are using the work practice controls contained in the standard. Additionally, the physician/employer must take steps to allow employees to comply with the standard, such as providing readily accessible hand-washing facilities or antiseptic towelettes in the event such hand-washing facilities are not feasible.

Personal protective equipment

The OSHA standard requires a physician/employer to provide employees with occupational exposure "appropriate" personal protective equipment such as gloves, gowns, laboratory coats, face shields, mouthpieces, resuscitation bags, and other ventilation devices.

Personal protective equipment is considered "appropriate" only when it does not permit blood or other potentially infectious materials to reach the employee's clothes, undergarments, skin, eyes, mouth, or other mucous membrane under normal

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

conditions and for the period of time in which the protective equipment will be used. A physician/employer is required to provide personal equipment to employees at no cost. Likewise, a physician/employer is responsible for laundering, repairing, and replacing personal protective equipment, also at no cost to the employee. The standard also requires personal protective equipment to be readily accessible to employees and available in appropriate sizes. In addition, hypoallergenic gloves, or other similar alternative, must be made available to those employees who are unable to wear the type of gloves normally provided by the physician/employer.

Use of personal protective equipment

The OSHA standard contains special rules about the use of personal protective equipment, and physician/employers are responsible for ensuring that their employees comply with each of these requirements.

The standard provides that employees must wear gloves whenever they reasonably anticipate hand contact with blood or other potentially infectious materials. Similarly, they must wear gowns, lab coats, or other outer garments whenever they reasonably anticipate any skin contact with blood or other potentially infectious materials. However, the standard does not require the gowns to be fluid-resistant unless it is anticipated that large amounts of blood or other potentially infectious materials will soak through the gown to the employee's clothing. Additionally, an employee must wear a face shield or a mask and protective eye wear whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination may be reasonably anticipated.

Employees are required to remove any personal protective equipment prior to leaving the work area. In addition, disposable gloves should be replaced as soon as practical following contamination. Gowns or other garments, however, must be changed immediately or as soon as feasible if penetrated by blood or other potentially infectious materials.

Citations issued by OSHA

OSHA will expect physician/employers to enforce the use of the required personal protective equipment. However, physician/employers may successfully defend themselves against citation for failing to require use of personal protective equipment by demonstrating that:

- employees were properly trained;
- the physician/employer took adequate steps to monitor compliance with the requirements of the OSHA standard; and
- appropriate and uniform discipline had been used on any prior occasion when failure to use personal protective equipment had been detected by the physician/employer.

A physician/employer is required to ensure that employers are using the work practice controls contained in the standard.

Housekeeping procedures under standard

Under the OSHA standard, physician/employers are required to establish an appropriate written schedule for cleaning and decontamination in order to ensure that their employees' workplace is maintained in a clean and sanitary condition. Likewise, all tray pails or similar containers that have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials must be inspected and decontaminated on a regularly scheduled basis. In addition to such scheduled cleanings, all equipment, containers, and working surfaces must be cleaned and decontaminated with an appropriate disinfectant following contact with blood or other potentially infectious materials.

Physician/employers may reduce their housekeeping burden by using protective coverings, such as plastic wrap, aluminum foil, or imperviously backed absorbent paper, to protect equipment and environmental surfaces from contamination. Such protective coverings, however, must be removed and replaced as soon as feasible when they become overly contaminated or at the end of the work shift if they may have become contaminated during the shift.

Disposal of contaminated sharps

Contaminated sharps, such as needles, scalpels, broken glass, and broken capillary tubes, must be discarded immediately or as soon as feasible in containers that are closable, puncture resistant, leakproof on the sides and bottom, and colored red or labeled "biohazard" and marked with the universal biohazard symbol. Physician/employers must ensure that contaminated sharps containers are easily accessible and are located as close as feasibly possible to the area in which the sharps are being used. Contaminated sharps containers must be replaced routinely, main-

tained upright throughout use, and not allowed to overfill.

If reusable containers are used, they may not be opened, emptied, or cleaned manually or in any other manner that would expose employees to the risk of percutaneous injury. The OSHA standard also prohibits broken glassware or other sharps that may be contaminated with blood or other potentially infectious materials from being picked up other than by mechanical means. As a final note, contaminated sharps containers must be disposed of in accordance with any other laws applicable to the disposal of medical waste.

Disposal of regulated waste

The OSHA standard defines regulated waste as blood or other potentially infectious materials, contaminated items that would release blood or other potentially infectious materials if compressed, items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling, contaminated sharps, and pathological or microbiological waste containing blood or other potentially infectious materials. Common examples of regulated waste, which may not be thought of as such, include tongue depressors, examination table covers, and thermometer sheaths.

The OSHA standard requires all regulated waste to be placed in containers that are closable; constructed to contain all contents and prevent leakage of fluids during handling, storage, transport, or shipping; colored red or labeled "biohazard" and marked with the universal biohazard symbol; and closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping. If outside contamination of the regulated waste container occurs, the contaminated container must be placed within a second container that meets all of the aforementioned requirements. As with contaminated sharps, regulated wastes must be disposed of in accordance with all other laws applicable to the disposal of medical waste.

Contaminated laundry problems

The OSHA standard provides that laundry soiled with blood or other potentially infectious materials should be handled as little as possible.

Contaminated laundry may not be sorted or rinsed at the location where it was used, but instead must be placed in bags or containers that are leakproof and colored red or labeled "biohazard" and marked with the universal biohazard symbol. In addition, employees must wear protective gloves and other appropriate personal protective equipment when handling contaminated laundry.

Employees may not, under any circumstances, take contaminated laundry home to be washed. Instead, the OSHA standard requires physician/employers to arrange for contaminated laundry to be washed at the workplace or by an outside laundry service. However, physician/employers are not responsible for laundering employee clothing that is worn under lab coats or other personal protective equipment.

Common examples of regulated waste, which may not be thought of as such, include tongue depressors, examination table covers, and thermometer sheaths.

Hepatitis B vaccinations

Physician/employers are required to make hepatitis B vaccinations available to each employee within 10 working days of the employee's initial assignment to a position involving occupation exposure unless the employee has previously been vaccinated, the employee is immune to hepatitis, or the vaccine is not recommended for medical reasons.

The vaccination must be provided at no cost to employees and at a reasonable place and time. Since the vaccination must be performed by or under the supervision of a licensed physician, a physician/employer may administer the vaccine to his or her employees. It is worth noting, however, that OSHA has stated that it ordinarily would not be advisable for physician/employers to vaccinate their own employees since it may lead to the assumption of unanticipated legal responsibilities on the part of the physician/employer.

The OSHA standard requires that physician/employers may not make participation in a prescreening program a prerequisite for receiving the hepatitis B vaccination. If an employee refuses to be vaccinated, the physician/employer must obtain from the employee a signed informed refusal form that states the following:

> *I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring*

Legal articles in Texas Medicine *are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.*

hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Although the OSHA standard does not address what to do if an employee refuses to sign the refusal form, a physician/employer would be wise to keep a record of any such refusal. As stated in the refusal form, a physician/employer is also required to make the hepatitis B vaccine available to any employee who refused to be vaccinated but later changes his or her mind.

Postexposure evaluation and follow-up

Following a report of an exposure incident, which is defined as a specific occupational incident involving eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials, the physician/employer is required to make immediately available to the exposed employee a confidential medical evaluation and follow-up.

The postexposure evaluation and follow-up must include:

- documentation of the routes of exposure, and circumstances under which the exposure incident occurred;
- identification and documentation of the source individual, unless the physician/employer can establish that identification is infeasible or prohibited by state law;
- collection and testing of blood for HBV and HIV serological status;
- postexposure prophylaxis, when medically indicated;
- counseling; and
- evaluation of reported illnesses.

The OSHA standard obligates physician/employers to try to obtain testing of the source individual's blood following an exposure incident. If the source individual's consent to testing is required by law and such consent has not been given, the physician/employer must establish that the source individual's blood cannot be obtained. If, however, consent is not required by law and the source individual's blood is available, the physician/ employer must secure testing of the blood and document the results of such testing. The postexposure evaluation also includes testing of the employee, provided the employee consents to such testing. If the employee only consents to the collection of a blood sample, but not to HIV testing, the physician/employer is required to preserve the blood sample for at least 90 days in the event that the employee decides to proceed with the testing.

Hepatitis B vaccinations must be provided at no cost and at a reasonable place and time.

Employees may decline to go through the postevaluation process. Under those circumstances, a physician/employer would be wise to document the employee's decision, preferably with an informed refusal form signed by the employee. It should be noted, however, that such documentation is not required by the OSHA standard.

Performing postexposure evaluation

The OSHA standard requires a physician/employer to provide the health-care professional performing the evaluation with a copy of the OSHA standard; a description of the exposed employee's duties as they relate to the exposure incident; documentation of the routes of exposure and the circumstances under which exposure occurred; results of the source individual's blood testing, if such results are available; and all medical records of the physician/employer that are relevant to the employee's treatment.

The physician/employer is further required to obtain and provide the employee with a copy of the health-care professional's written opinion within 15 days of the completion of the evaluation. However, the opinion must only provide that the employee has been informed of the results of the evaluation and that the employee has been told about any medical conditions resulting from the exposure incident that require further evaluation or treatment. All other findings or diagnoses must remain confidential between the employee and the evaluating health-care professional.

Information must be provided prior to vaccine administration

Hugh M. Barton, JD
TMA Assistant General Counsel

On April 15, 1992, federal regulations went into effect that require physicians who administer certain vaccines to children to provide information about the risks and benefits of those vaccines (1). This information is to be provided to the parent or guardian of the child prior to vaccination.

Q: Which vaccines are specifically covered by the rules?
A: Vaccines that immunize against diphtheria, tetanus, and pertussis (DTP); measles, mumps, and rubella (MMR); and poliomyelitis.

Q: What information is to be provided?
A: The National Childhood Vaccine Injury Act requires that materials be prepared "in understandable terms" and distributed covering the following 10 areas:

1. the frequency, severity, and potential long-term effects of the disease to be prevented by the vaccine;
2. symptoms or reactions to the vaccine that should be brought to the physician's attention immediately;
3. measures parents can take to reduce the risk of major adverse reactions;
4. early warning signs of major adverse reactions that parents should be aware of;
5. how parents should "monitor" adverse reactions, including forms to record such events;
6. when, how, and to whom parents should report adverse reactions;
7. contraindications to administration of the vaccine;
8. which groups of potential vaccine recipients may be at risk of adverse reaction;
9. a summary of relevant federal recommendations about a complete schedule of childhood immunizations and the availability of the National Vaccine Injury Compensation Program; and
10. other relevant information as the government determines (2).

Q: Where can I obtain this information for my patients?
A: The Centers for Disease Control (CDC) has developed three pamphlets that satisfy the criteria. They are titled: *Diphtheria, Tetanus and Pertussis: What You Need to Know; Measles, Mumps, and Rubella: What You Need to Know;* and *Polio: What You Need to Know.* Copies of the publications are available from the TMA public health and scientific affairs department (800) 880-1300, ext 1461. For questions about the regulations and forms, contact Wes Hodgson, Texas Department of Health, immunization section, at (512) 458-7284.

Q: Will the CDC send me a free pamphlet for each parent to whom I have to give this information?
A: No. The Texas Department of Health will send pamphlets to every physician licensed in Texas, but it will be the physician's responsibility to copy these materials and provide them to parents. Public sector clinics, however, will be provided free pamphlets to hand out to parents.

Q: Am I legally required to use these pamphlets?
A: No. You may develop your own materials, but they must satisfy the 10 statutory criteria.

Q: I've seen one of these pamphlets. The last page is titled "Vaccine Administration Record" and is scored to be torn off. What do I do with this form?
A: This is a two-part form. The first page is a "Request for Immunization" to be signed by the parent, and the second page has space to enter the location of the office, vaccination date, drug manufacturer, and other information.

According to the CDC, the Request for Immunization form must be signed by the parent if the vaccine is purchased from a federal contract. Thus, public sector clinics and private physicians who purchase vaccines from federal vaccine purchase contracts will require signatures. On the other hand, if the vaccine is purchased from a manufacturer and administered by a private physician, no signature is required, according to the CDC.

However, it may be advisable to obtain a signature in any case to show that the information was provided, read, and understood before immunization took place.

Q: Will parents really read and understand this material?
A: This is a controversial issue. The pamphlets were developed in a joint effort with a number of advocacy groups that have an interest in vaccine injury litigation, such as the Children's Defense Fund and Determined Parents to Stop Hurting Our Tots ("DPT SHOT"). As a result, some believe that the pamphlets are too long, too detailed, and overly legalistic. There is already some movement to shorten the pamphlets (3).

Q: Are the pamphlets available in other languages besides English?
A: Yes. They are available on request in Chinese, French, Spanish, and Vietnamese.

Q: Who does this law protect?

A: The National Childhood Vaccine Injury Act of 1986 was intended to provide a solution to the vaccine liability crisis. As part of that solution, physicians who administer these vaccines have been required to report certain adverse events after vaccination since March 21, 1988. The law is designed to protect vaccine manufacturers and physicians who administer vaccines by providing that no vaccine-related injury or death litigation may be brought in state or federal court unless certain administrative procedures are first met. These procedures were designed to provide a "no-fault" remedy and reduce litigation. For example, compensation awards do not include attorney fees (4).

The results have been mixed. On the one hand, it has been held that state law products liability claims are not preempted by the federal law (5). On the other hand, parents seeking compensation under the federal law have been required to dismiss their state law claims as an absolute prerequisite for obtaining the federal remedy (6).

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Offshore investments can provide security in certain situations

Duncan E. Osborne, JD
Graves, Dougherty, Hearon & Moody
Austin, Texas

FINANCIAL ADVISORS ARE increasingly turning their attention toward a planning tool that has previously received little attention from US investors — the offshore asset protection trust.

Individuals have begun to consider the offshore trust as a way of avoiding the effect of impoverishing jury awards. The spiraling amounts of judgments against defendants and the general failure of tort reform legislation have caused many individuals to consider offshore trusts as an alternative for protecting family security from such risks.

While not a panacea, in certain situations the offshore trust can facilitate the protection of wealth from the exposures of both the judicial system and economic environment.

Unfortunate connection to shady activities

Due to aggressive tax avoidance schemes and the activities of various drug cartels during the past several years, the term "offshore trust" has, for many people, acquired an unfortunate connection with money laundering, tax fraud, and other shady activities.

Indeed, offshore corporations and trusts have a history tainted with abuses. However, there is an entirely legitimate offshore industry devoted to financial services. Professionals of high integrity and considerable expertise and responsibility operate financial centers in foreign lands such as Bermuda, the Isle of Man, and Liechtenstein. Trust bankers, attorneys, and investment advisors in offshore jurisdictions assist corporations and wealthy individuals with financing, legitimate tax and corporate planning, portfolio management, maintaining investor anonymity, asset protection, and other financial matters. Many of these services are quite comparable to those that may be obtained in any major city, but with flexibility generally not available within the US legal system.

Advantages of offshore investments

What are the advantages of offshore investments? Global diversification may provide a hedge against risks from the US economy. The US economy has been highly criticized of late, and indeed, as the move toward a more integrated international economy continues, it appears that the European economic community and the dominant economies of the Far East, Japan, and Korea are poised to compete in this environment. The reality of these forces is reflected in the advice of professional portfolio managers who are beginning to urge investors of the need to diversify into foreign securities.

In addition to erosion due to adverse economic conditions, sudden and precipitous assaults on wealth can occur through the legal system. Premiums are soaring, insurers continuously narrow the scope of covered events, and insurance companies themselves are failing. Indeed, the major challenge to the preservation of wealth may no longer be the tax collector, but the plaintiff's lawyer.

In addition to the threat of court judgments, traditional diversifying investments in real property have become associated with a new class of risks apart from the usual economic fluctuations. Mere passive investors

who had no hand in creating environmental liability and who had no knowledge of prior uses of property could find themselves footing the bill for environmental clean-up costs due to the fact that they have the only "deep pockets" available. Given the breadth of liability that CERCLA and similar environmental clean-up statutes impose upon all individuals or entities with an interest in contaminated property, an apparently "safe" investment in real estate may carry staggering hidden liabilities.

In addition to persons potentially subject to the foregoing economic threats, certain types of investors can obtain particular benefit from the offshore trust. Risks of client claims or business-related liability make professionals and business persons whose endeavors inevitably put their wealth at risk obvious candidates for offshore trusts. Persons with inherited wealth or substantial accumulated wealth should also consider the benefits of diversification of assets and reduced exposure in the US market. In addition, individuals who wish to take advantage of the anonymity of foreign investment may find the offshore trust attractive.

The type and value of assets comprising the investor's current holdings may also point toward an offshore trust as a valuable planning tool. Liquid assets, such as stocks, bonds, and other portfolio investments, are readily susceptible to offshore planning. While there is no required threshold amount, start-up costs and annual servicing costs tend to dictate mid-six-figure values as a minimum investment justifying establishment of an offshore trust.

The offshore trust offers two primary advantages over US-based investment in foreign entities. First, assets placed under the management of a European or Pacific Rim portfolio advisor are likely to be invested with a more critical view of the US economy and certainly with a different perspective than would funds invested by a US manager. This on-site expertise has a decided advantage over a stateside advisor trying to make the same call.

The second advantage is that a properly structured investment portfolio held by an offshore trust or other foreign legal entity can be placed beyond the reach of US creditors, including judgment creditors. While the form of the offshore entity is important, timing is the most critical factor.

Typically, an offshore trust should be set up when there is no question about the settlor's present and continued solvency. As is the case with domestic transfers to a trustee or other third party, bankruptcy laws and laws prohibiting fraudulent transfers generally will render transfers to an offshore entity ineffective if a creditor is already on the horizon. Therefore, if a suit has even been threatened, it may be too late to use an offshore solution.

As well as careful timing of investment, proper legal structure and competent tax advice also are essential. Since offshore entities were historically used to avoid US taxes, complex reporting and financial disclosure rules have been enacted to combat these abuses. While these rules generally impose little threat to the legitimate investor, competent and thorough tax advice is necessary in order to avoid unintended penalties under these rules. An investor contemplating an offshore trust as a tax-saving vehicle should, however, be aware that tax savings are generally just not possible with passive portfolio investment as would be typical of an offshore trust.

Selecting advisor and country

Investors considering offshore investment should take care in choosing advisors, both at home and abroad. The tax and legal issues can be a mine field even for a generally competent advisor who is inexperienced in the offshore arena. Certainly references and credentials of both local and foreign professionals should be scrutinized. An investor also must be clear about fees and related costs, both start-up and recurring.

In addition to selecting advisors, careful thought must also be given to selecting an appropriate country in which to locate the offshore entity. Common jurisdictions include Bermuda, the Cayman Islands, the Channel Islands, the Isle of Man, Gibraltar, and Liechtenstein, but there are other options and different countries offer varying advantages. Cost, convenience, and political and economic stability are factors to be considered in selecting an appropriate jurisdiction for offshore investment.

Offshore trusts are not a cure-all and should only be considered when they are consistent with an individual's other planning and financial arrangements. However, in certain situations, offshore entities can provide a form of meaningful protection not otherwise available through domestic legal structures. ★

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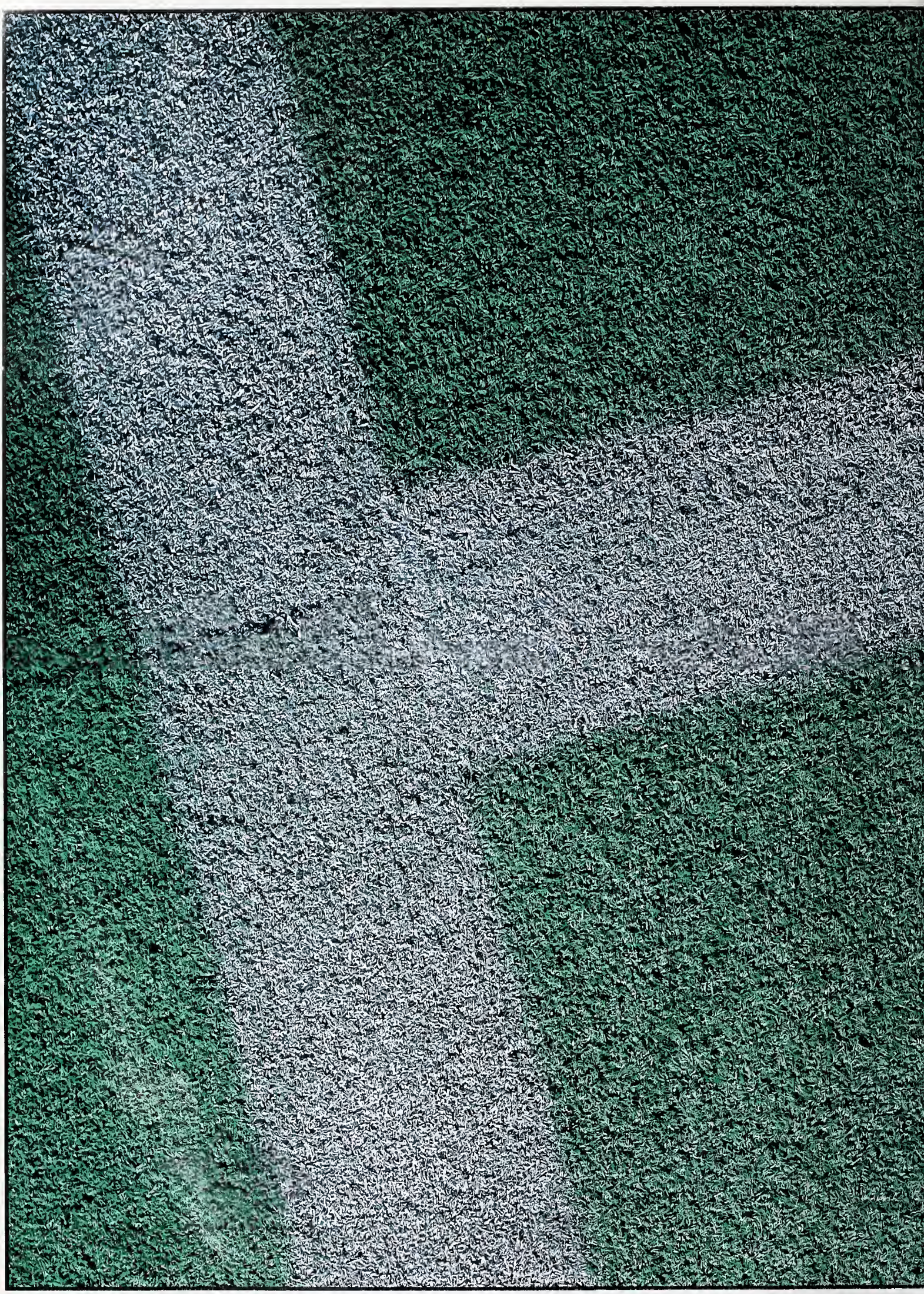


THE BREAKS OF THE GAME

SPORTS MEDICINE IN TEXAS

BY LAURA J. ALBRECHT
Associate editor

Some put it on the line before 70,000 screaming fans on Sunday afternoons. Others spend mornings in class, a lifetime of afternoons in the gym, and nights at the library. And then there are those whose only field of competition exists within their own minds.

Although they lead diverse lives, the professional, amateur, and weekend athlete share something besides the desire to compete. It's called getting injured.

And that's where sports medicine comes in.

Sometimes the injuries are physical. Sometimes they're emotional. But whatever the ailment, Texas physicians are valuable members of sports teams and athletic programs.

Their jobs can be as complex as performing knee surgery on a multimillionaire basketball player or as seemingly simple as encouraging an NBA-wanna-be who's just shoveled up a 3-pointer only to have it fall a mile short of its intended destination.

While orthopedic surgeons have long been identified as the "doctor" in sports medicine, they now are being joined by colleagues from specialties such as pediatrics, family practice, gastroenterology, psychiatry, and adolescent medicine.

Jesse DeLee, MD, a San Antonio orthopedic surgeon and former chairman of the Texas Medical Association Committee on Sports Medicine, treats injured elite athletes and educates others about athletic injuries. "In the real practice of sports medicine the majority of things you treat are nonsurgical," he says. "The glamour in sports medicine appears to be in the surgical treatment, but you have to realize that less than 5% of sports injuries require surgical treatment. A greater number of patients suffer from overuse injuries.

"Family practitioners are becoming more and more involved because orthopedic surgeons can't see all the patients coming in with injuries," he says. "They do a tremendous job in this area."

Albert Hergenroeder, MD, chief of adolescent medicine and sports medicine at Texas Children's Hospital in Houston, says the trend toward a multidisciplinary approach to sports medicine will continue. "The future of sports medicine is a fusion of all specialties involved in taking care of athletes," he says.

HOW FAST, HOW HIGH, HOW FAR??

Scientific research into human performance benefits more than just the elite athlete.

"Our goal is to bring the techniques of exercise and sports science to the everyday care and management of people," says Ben Levine, MD, an assistant professor of internal medicine at The University of Texas Southwestern Medical Center at Dallas. "We want to understand performance. This might be an elite athlete who wants to run a mile under 4 minutes or a patient who has suffered heart failure and needs to be able to make it out of bed."

The Dallas cardiologist says understanding the limits of performance in one group can help another group. "When I study elite world-class mountaineers on Mt Everest, I learn the effect of extreme hypoxia. This gives me tremendous insight into patients who suffer from lung disease and who are hypoxic everyday."

Treating Aggie Athletes is No Joke

Consider the complexities of a college athlete's life: the pressure to perform not only on the field but in the classroom, multiplied by the pressure to stay injury-free and healthy.

Bryan-College Station pediatricians Jesse Parr, MD, and Patricia Goen, MD, understand the inner workings of these individuals. Their patients include members of the men's and women's Texas A&M University athletic teams.

Dr Goen began treating elite athletes on the college level when a colleague was unable to fulfill her commitment as team physician.

It was while playing guitar with a church music group that Dr Parr learned from the head trainer at Texas A&M that a search was on for a team physician. "I accepted as a favor to him and it has worked out very well," says Dr Parr about his 9 years working with the Aggie men's athletic teams.

Both physicians say sports medicine has added a new dimension to their lives and practices.

"There's no way to be a team physician and not get emotionally involved in wanting (the athletes) to win," says Dr Goen. "I see how hard they work. Sports medicine is one of the things I enjoy the most about my practice."

Dr Parr says one bonus from working with college athletes is that his teenaged patients are less likely to drift away. "My identification with university teams has made it more acceptable for high school and junior high kids to continue seeing their pediatrician," he says.

The pediatricians acknowledge that college athletes are no different from their non-jock counterparts in many health areas, but treating them requires more than x-rays and nutrition counseling. They suffer from homesickness; they fall in and out of relationships; they struggle with school work. But on top of this, they face the brand new stress of participating with other athletes who are at least their equals. The star of the high school team is now not the only shining star on the team.

"All of a sudden they are surrounded by others who have the same abilities," says Dr Parr. "For the first time in their lives they experience competition and really have to work for a position. They are going from being the star of the team to a reserve role. It's a hard psychological blow."

Student athletes not only have to meet the demands of competition, but they also face unusual social pressures. Many are living away from home for the first time and have access to favors not offered to everyone. Drugs and sexual favors are common offers.

"A lot of these guys have not learned to deal with all the adulation," Dr Parr says. "They have difficulty sleeping, suffer fatigue, and have trouble concentrating. There is a high level of stress to deal with."

And no small part of the pressure is the need to stay healthy. That, says Dr Goen, also places pressure on the athletes' physicians.

"You really have to stand your ground," she says. "The athletes want you to do something because they have to play."

To Dr Parr, that situation requires not letting an athlete do anything dangerous to his or her health while being careful not to make a decision unnecessarily detrimental to the success of the team.

But protecting the health of athletes means more than just attending to game-related injuries. The students sometimes have problems, such as eating disorders, that began long before college.

One of Dr Goen's primary concerns has been the incidence of eating disorders among female athletes. She says a lot of the problem stems from the control factor that relates to the athlete's performance. A seemingly supportive family environment can turn into a controlling atmosphere that can trigger an eating pattern disruption.

"The first year I saw a couple of athletes with eating disorders, then more during my second year," she says. "I think I see more now because I am keyed into it." To assist in understanding and solving the problem, Dr Goen enlisted the assistance of a dietitian and also met with coaches to explain the situation.

Another illness Dr Goen sees in athletes is chronic fatigue syndrome (CFS). "Athletes experience CFS more than the average student because they are trying to balance their sport, studies, and sometimes a relationship," she says. "They come to me complaining of lack of sleep, loss of appetite, and lack of drive."

Dr Goen schedules one morning a week to see her athlete-patients. This provides an opportunity not only to treat their injuries or illnesses, but also to enjoy casual conversation. Home is a long way off for many of the athletes and "sometimes they just need to talk," she says.

What happens when graduation becomes reality and the Saturday afternoons that once were filled with adoring crowds and the thrill of victory are no more?

"One of the things we focus on is getting the athlete prepared for life after sports," says Dr Parr. "It is interesting to learn that a lot of the players get sports out of their system in college and really don't miss it as much because it has been such a hard job. I enjoy watching them grow up just like any other college student. They come in as freshmen and leave to join the rest of the world."

For some of the students who leave sports, it is the first time since their very early years that the pressure to perform athletically has not been a major part of their lives.

AMERICANS LOVE THEIR SPORTS

In 1990, Americans spent $44.1 billion on sporting goods equipment, including clothing, footwear, equipment, and recreation transports (such as all-terrain vehicles).

The numbers of participants in the leading sports in 1990, according to the National Sporting Goods Association, were:

- exercise walking: 71.4 million
- swimming: 67.5 million
- bicycling: 55.3 million
- fishing: 46.9 million
- camping: 46.2 million
- bowling: 40.1 million
- exercising with equipment: 35.3 million
- power boating: 28.6 million
- pool/billiards: 28.1 million
- basketball: 26.3 million
- running: 23.8 million
- aerobics: 23.3 million
- volleyball: 23.2 million
- golf: 23.0 million
- hiking: 22.0 million
- calisthenics: 13.2 million
- backpacking: 10.8 million
- mountain climbing: 4.7 million

THE FRAGILE SIDE OF ATHLETICS

A 4-year-old "goalie" eyes a pebble buried in the soft sand. He picks it up and cradles his newfound treasure. A lucky discovery for the day. But then reality intrudes. A black and white ball rolls patiently by to his left. He glances over at the invader, then back at his treasure. Screams break the silence of his universe. A goal has been scored. And, unfortunately, this little soccer player will probably suffer the wrath of his inexperienced coach, socially embarrassed parents, and, maybe, fellow teammates.

"Everybody thinks their son or daughter is going to be the next gold medal winner and end up with a million-dollar contract," says Dr Hergenroeder, who in addition to his affiliation with Texas Children's Hospital is associate professor of clinical pediatrics at Baylor University College of Medicine. "We are crushing 99,999 little kids to get that one who is going to go on to be a superstar.

"Sports is a double-edged sword. For the kids who are athletically inclined and obviously good at a particular sport, it's great. But to the extent we exclude kids from sports because they can't throw the ball quite as well or kick it as far, that really is a mistake," he says. "The whole purpose of sports is to give kids another way of bettering themselves. This comes through achieving better fitness, learning companionship, developing sportsmanship, and working toward leadership roles. They can't learn if they are not part of a team. We need to make an effort to ensure that everyone plays."

There have been two major pushes in the country when it comes to the direction of sports, says Bill Farney, PhD, University Interscholastic League athletic di-

rector and consultant to the TMA Committee on Sports Medicine.

One side promotes sportsmanship and participation. The focus is on self-awareness, self-image, and taking part in activities that will teach responsibility and cooperation. On the other side is the Olympic "Go for the Gold" and forget everybody else. An overemphasis on the individual leads to the abandonment of the average and sometimes even the good athlete.

"There is nothing wrong with being all you can be," says Dr Farney. "But not at the expense of losing your childhood. And not at the expense of other positive psychological and physiological developments. We have sacrificed some of our kids for that."

He says approximately 94% to 96% of high school athletes will not participate in competitive team sports after graduation. Only 4% to 5% go to college on sports scholarships, which is why he believes programs should not focus on just the few top athletes.

"The most important reason for kids to play sports is to have fun," says Bryan-College Station pediatrician Jesse Parr. He adds that coaches and parents should do all they can to make sure their kids are having fun and are being taught by people who know the desired skills. To Dr Parr, children should be respected as human beings and not pawns in somebody else's climb to the top.

In addition to working with the A&M teams, Dr Parr has also been a high school team physician and has coached Little League baseball. "I taught my kids to play hard, play to win, have fun, and never give up," he says. "I didn't tell them they had to win but, if they weren't trying to win, then they had no business being out there."

However, the act of sports participation does get more intense as the stakes get higher. "For many athletes at the university level *fun* is not the primary reason they are participating," says Dr Parr. "They are participating to get an education and possibly a professional career. It is enjoyable, but not as much as when they played sandlot ball."

But fun or no fun, almost all athletes face injuries and many need help in negotiating the road to recovery.

"I KNEW THE KNEE WAS GONE."

It was a tear to the anterior cruciate ligament that sent Vicki Hall, basketball standout at The University of Texas, crashing to the floor during the first game of her senior season in 1991.

Ms Hall, who had been injury-free up to that point, says, "As soon as it happened, I knew the knee was gone."

"This is a relatively common injury in basketball," says Jesse DeLee, MD, San Antonio, who performed her surgery. "Our biggest problem with Vicki has been holding her back during rehabilitation. Of course, this is not uncommon with elite athletes."

After the injury, Ms Hall began a quest to return to the court. "I focused on moving forward to get surgery out of the way and the knee back in order," she says. "There are moments of doubt, but I have to have a positive attitude."

Ms Hall's surgery was 18 days after her injury, and she is in an intensive rehabilitation program under the direction of Tina Bonci, UT's head trainer. She wants to return to the basketball court for the 1992 season.

"A return to athletics after an injury is almost totally up to the player," says John Pearce, MD, an orthopedic surgeon who assisted in Ms Hall's surgery. "We can do the best surgery in the world and if the athlete is not dedicated to the rehabilitation the surgery is not going to do them any good."

UNDERSTANDING THE ATHLETE-PATIENT

A patient with a passion for running begins experiencing pain in his knee. He goes to his family doctor who tells him to stop running for 2 to 3 weeks. He pays his bill, walks out, and continues to run. Neither the patient's nor the physician's treatment goal is accomplished.

"You have to understand the psychology of an athlete before you start working with him," says Dr Hergenroeder, who adds that sports have always played a major role in his own lifestyle.

"Athletes don't go to the doctor to be told what they can't do," he says. "They go because they can't do what they want to do and they want to know what they can do to get better."

Consequently, Dr Hergenroeder is careful to explain the patient's situation through a series of educational tools — charts and models of specific parts of the anatomy. "I explain the anatomy of the injury and tell the patient what is going on and why there is a need to improve flexibility and strength," he says. He also works hard to design a rehabilitation program that is right for each athlete, since athletes vary widely in their approach to sports.

Family physicians are likely to encounter two basic types of recreational athletes. One group is extremely serious about exercise. They work out 3 to 4 times a week and can experience stress fractures, chronic knee pain, rotator cuff injuries, and ailments relating to weight lifting. The other group, the so-called weekend warriors, sit at desks all week and then storm the weekend with 3-hour workouts. Their "injuries" are predictable: they can't walk on Monday.

"These groups are trying to achieve fitness in different ways," says Dr Hergenroeder. "One group is ending up with injuries as a result of being overzealous and the oth-

er group has not adequately prepared for exercise."

Probably nobody would claim that the public as a whole is exercising too much, but many individuals overdo it. "There are some instances when the very serious amateur athlete is exercising to the point that it impinges on his or her career," says Dr Hergenroeder. "In fact, there are instances when patients may exercise to the point that it interferes with career and interpersonal relationships." Exercise is good, he says, but if a patient reaches the point that he becomes depressed or irritable when he misses a workout, then it's time to encourage him to broaden his interests.

It's also important to tell patients to work up to exercise gradually, he says. Instead of the popular misconception of "no pain, no gain," he tells patients to pay attention to any pain and adopt a "no work, no gain" attitude.

As John Pearce, MD, an orthopedic surgeon who works with The University of Texas women's athletic program, says, "Individuals should get in shape to play a sport and not play a sport to get in shape."

THE PROS: DROPPING THE GAME-WINNING PASS

Dallas psychiatrist Mark T. Unterberg, MD, has become fascinated with the significant role that sports can play in people's lives, regardless of whether they're professionals, amateurs, or spectators.

"We have to assume that sports play a big role in people's lives as children or they wouldn't be such fans as adults," he says. "Why are there 60,000 people at the football stadium? And why are they so fanatical? There has to be something in their past involving sports.

"If you ask a majority of males about their historical involvement in sports, they will be able to remember if they were chosen first or last on the team," he says. And that status with the team probably affected both their self-esteem and their classroom performance, he says.

But school students aren't the only ones whose self-esteem is affected by sports. Professional athletes can depend heavily on public worship for their own sense of worth.

"The professional athlete gains both praise and criticism and experiences tremendous exposure to society," says Dr Unterberg, whose practice includes treating professional football players. "There is also the financial remuneration." But, he points out that these factors can create problems.

The lives of many professional athletes whose special gifts were evident from a very early age have centered around sports to the extent that they didn't develop in other areas. "Take, for example, the high school football star who didn't have to work to be popular," says Dr Unterberg. "He didn't have to do anymore at a party than just show up. People support his view that he is special."

We all want that kind of easy adoration, he says, but most of us know it's not reality. For the professional athlete, it's when reality sets in that real problems can surface.

Imagine dropping the game-winning pass in front of 60,000 screaming fans and then reading about it in the newspaper for the next 4 days. "When country club players lose a tennis match, it is no big deal because they have other things going on in their lives," says Dr Unterberg. "However, when professional athletes lose, this is their whole life. They have put everything into it; therefore, the reactions are magnified."

But even nonprofessional athletes can depend too heavi-

WANT TO BE A TEAM PHYSICIAN?

Many physicians who volunteer to oversee the health of high school athletes say it's well worth the time and effort.

"It's an avocation rather than a vocation," says David Coble, MD, a Sherman pediatrician who has volunteered his skills for 16 years. "For those of us who do become involved, it is a meaningful part of our medical practice."

One of the things he enjoys about volunteering is watching students thrive as a result of their sports involvement.

"It is amazing how you can help a girl or boy who doesn't have that much ability really start to feel good about themselves," he says. But he also has some concerns about coaches who push kids too far and too fast. He worries about the children who start sports young and become burned out by the time their real abilities begin to develop.

For the last 10 years, Dr Coble has coordinated with other specialties — orthopedists, ophthalmologists, urologists, and family practitioners — to provide pre-participation exams for male and female athletes. The exams not only prepare the high school athletes for the competitive season but also provide an opportunity for the physicians to discover any abnormalities.

Depending on the size of the school district, a team physician might be responsible just for the football squad or he or she might also become involved with other sports such as men's and women's basketball, baseball, swimming, volleyball, and tennis teams.

"A lot of doctors don't get involved due to liability concerns," says Art L. Klawitter, MD, a family practitioner and team physician in Needville and chairman of the TMA Committee on Sports Medicine. "But we need to be out in the community and show our support."

A spokesperson from the TMA Office of General Counsel suggests that physicians notify their professional liability carriers if they choose to volunteer as team physicians.

ly on sports for escapism, says Dr Unterberg. "The main thing is to maintain a balance. If all a person does is sports and it is hampering other areas of development, then the person has to be helped to develop the ability to deal with the realistic aspects of life."

Dr Unterberg's original career plans didn't include treating patients who catch and throw a football for millions of dollars. With a background in high school and college sports, he began operating a program for the US Marines in 1976 treating substance abusers.

It was in this era that the National Football League saw an increase in alcohol and drug abuse. Although alcohol abuse had long been recognized as a problem, it was not widely publicized. As concern about cocaine use also grew, the league decided to confront substance abuse problems more directly by passing rules that require teams to have a substance abuse consultant. Because of Dr Unterberg's experience treating patients with these problems, he was contacted and began focusing on the treatment of elite athletes.

To him, the most perplexing question surrounding substance abuse and athletes is: "Why would they sacrifice all the good by becoming addicted to cocaine and alcohol?" This is particularly puzzling given that athletes are at their best only when totally focused on the game and not distracted by substance abuse problems or family or personal problems.

Treating those athletes that succumb to substance abuse problems requires a recognition that they are special.

"Even the treatment has to be different because these people are completely different and their life experiences are different," says Dr Unterberg. "The majority of the athletes I see who turn to drugs have a past history of using them socially." The huge salaries associated with professional sports have a tendency to attract drug dealers.

Drug abuse also is a pitfall for the professional athlete who goes from being at the top of his game into a downward turn. "Sometimes this frustration is not dealt with in a healthy way and little-by-little they turn to drugs," says Dr Unterberg. "It's self-medication and then it catches up with them. A lot of it has to do with old patterns or they are just not mature enough to deal with the frustrations. They have to create and find different ways to deal with the problems and achieve good feelings."

As his work with the substance abuse problems of the athletes progressed, Dr Unterberg also turned his attention to the involvement of coaches and family in athletes' lives.

Many athletes have problems making the adjustment to professional ranks because they miss the support system provided by their high school or college coach, he says. Their dependence on the paternal role of the coach to "take care of things no matter what happens" can lead to an attitude of "it won't happen to me" and "I won't get caught," which fuels the use of drugs and, at times, disrespect for laws.

Another area in which Dr Unterberg assists the athletes is their psychological response to physical injury, since that can play an important role in recovery. And the fact that an injury can end a career cannot be ignored.

"I have worked with athletes who have been injured and recovered and I have worked with some whose injuries have terminated their careers," says Dr Unterberg. "Either way you can't ignore the impact of the injury."

In some instances, he has seen athletes who appear to be getting injured more often than they should. At that point, he asks himself questions like, "Is this player doing things that are making him injury prone?" or "Is he getting injured because he thinks he is Superman and is overdoing it?"

Dr Unterberg recalls one player who was suffering from repeated injuries. It became clear, he says, that he really didn't want to play the sport anymore, but because of finances and ego he wouldn't leave the game.

WHERE TO GO FOR MORE INFORMATION

Following are organizations with additional information about the field of sports medicine.

Texas Society of Sports Medicine
Contact Tarek O. Souryal, MD, 2001 Ross Ave, Suite 3090, Dallas, TX 75201, (214) 979-3434, or Ted Edwards, MD, 4615 Bee Caves Rd, Austin, TX 78746, (512) 327-4886.

Texas Medical Association Committee on Sports Medicine
Contact Miriam Blum, TMA, 401 W 15th St,Austin, TX 78701-1680, (800) 880-1300, ext 1547.

Texas Orthopaedic Association
Contact Donna Parker, TMA, 401 W 15th St,Austin, TX 78701-1680, (800) 880-1300, ext 1528.

Texas Pediatric Society
Contact Mary Greene, TMA, 401 W 15th St, Austin, TX 78701-1680, (800) 880-1300, ext 1527.

American College of Sports Medicine
401 W Michigan St, Indianapolis, IN 46202-3233, (317) 637-9200.

American Academy of Pediatrics
PO Box 927, Elk Grove Village, IL 60009-0927, (708) 228-5005.

American Medical Society for Sports Medicine
7611 Elmwood Ave, Suite 202, Middleton, WI 53562, (608) 831-4484.

All patients are (potential) athletes

Only rarely will the average family physician treat a 295-pound offensive guard who makes his living in the trenches of the NFL. But all patients should be considered athletes and every physician should be a ports medicine doctor, says Ted Edwards, Jr, MD, who ıas treated both recreational and Olympic athletes.

"All patients should exercise, and physicians should ınderstand what to do to take care of them," says the \ustin gastroenterologist. "Sports medicine is not limted to knee and shoulder injuries. It is really all the asɔects of how physicians take care of somebody who is ıctive physically."

He adds, "Most people still think that sports nedicine is essentially emergency care rendered on the ield and the ideal 'sports medicine physician' is an orhopedic surgeon who treats the elbow, arm, shoulder, ɔr knee."

His introduction to sports medicine came as a team ɔhysician at an Austin-area high school. During this ime, he developed his theory of wellness that combines stress management, nutrition, and exercise. In the late 1970s, he built the Hills Fitness Center in Austin as a otal wellness facility. He operated the facility for 7 years before selling it and returning to private practice.

While he was with the fitness center, the US Olympic Cycling team was training in Austin and using the facility. Dr Edward's involvement with the cyclists led to his volunteering as a physician for the US Olympic team. He selected Lake Placid as his first "Olympic assignment," figuring that "if I was going to be a complete sports medicine physician I might as well learn about winter sports as well as summer sports."

Many of Dr Edwards' views were formed working with the average athlete. While elite athletes are intently focused on the demands of their sport, "the rest of us are more intent on going to work," he says. "When I go skiing there is no sense in me going all out because on Monday morning I am going to be back in the office and I want my legs and knees to work. I am not going to take the chance an elite athlete would take. The focus is on how I am going to stay healthy."

Treating all patients as if they were athletes has proven successful in Dr Edwards' practice and it's a philosophy he recommends to his colleagues. "I think it has been successful because we know this philosophy works," he says. "Physicians have told me they can't get their patients to follow prescribed good health routines. But I tell them they are probably not enthusiastic enough about the information they are sharing with their patients. We take this attitude because we know it works." ★

AIDS: TO TEST OR NOT TO TEST

Steroids, blood doping . . . and HIV. Another invader has joined the sports community. Announcements by basketball star Earvin (Magic) Johnson and tennis legend Arthur Ashe about their positive HIV status have magnified the reality of AIDS and sports.

Since physical contact occurs in events such as basketball, football, soccer, and wrestling, questions have been raised about whether athletes should be tested for HIV, but consensus on the issue seems a long way off.

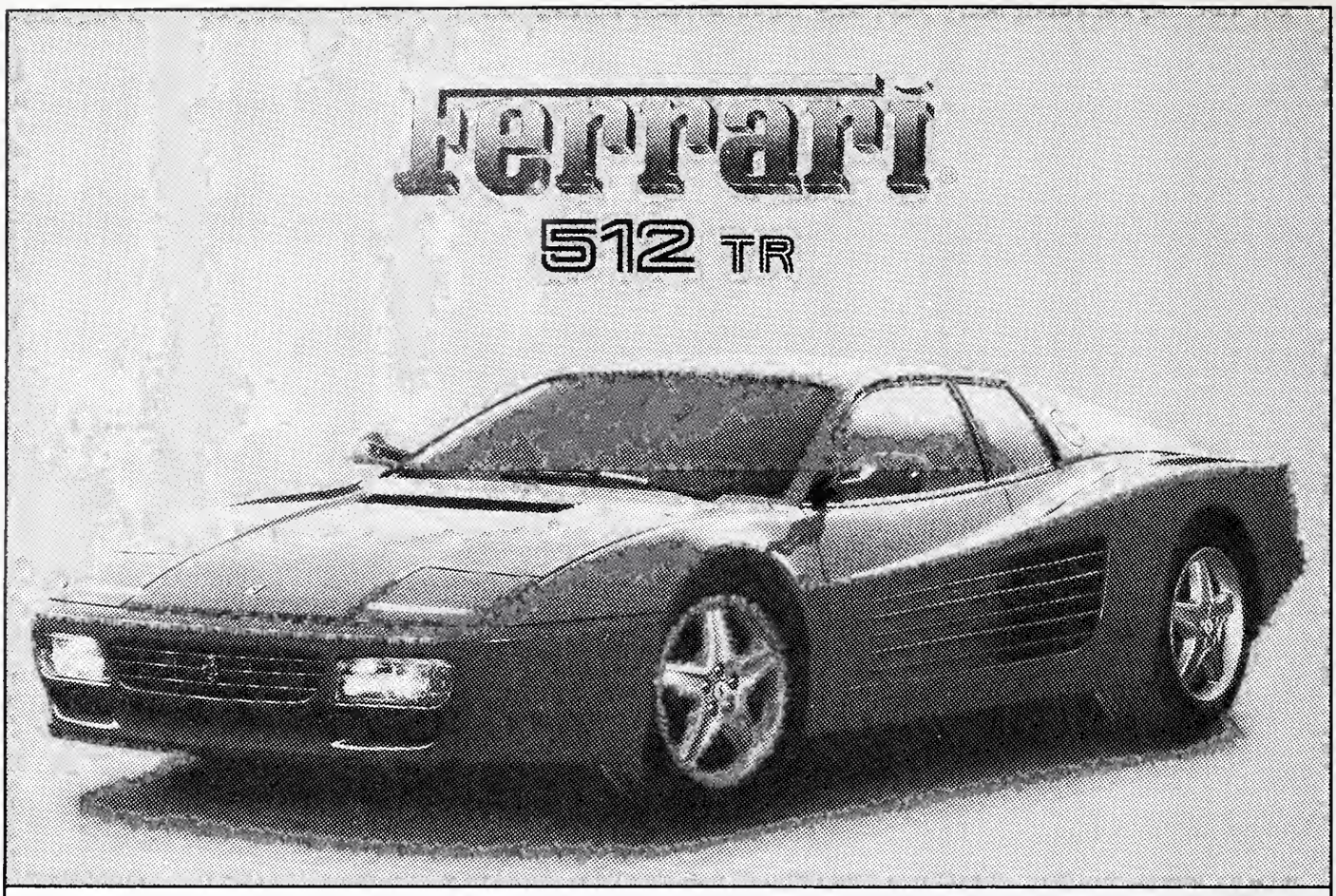
"There has been concern about HIV testing due to contact in certain sports," says Bill Farney, PhD, athletic director for the University Interscholastic League.

Jesse Parr, MD, of Bryan-College Station, whose patients include college athletes, sees growing concern among football players and wrestlers. "Athletic trainers are now using universal precautions when working with injured athletes due to the possibility of exposure to blood," he says.

Patricia Goen, MD, a team physician for college athletes, is coordinating a seminar to educate female athletes about HIV and sexually transmitted diseases. "We need to open the female athlete's eyes and make sure they avoid risk-taking behavior," she says.

The American Academy of Pediatrics has issued a policy statement on AIDS in the athletic setting. In addition to the use of universal precautions by coaches and athletic trainers, the academy recommends:

- Athletes infected with HIV should be allowed to participate in all competitive sports. This advice must be reconsidered if transmission of HIV is found to occur in the sports setting.
- A physician counseling a known HIV-infected athlete in a sport involving blood exposure, such as wrestling or football, should inform him of the theoretical risk of contagion to others and strongly encourage him to consider another sport.
- All athletes should be made aware of the above recommendations.
- Routine testing of athletes for HIV infection is not indicated.
- Coaches and athletic trainers should receive training in prevention of HIV transmission in the athletic setting.



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Legislative Affairs

More bills filed to correct GPCI problems

MOMENTUM FOR A congressional fix of problems with Medicare's geographic practice cost index (GPCI) continues to build with the introduction of two companion measures to TMA-supported legislation to require use of more accurate data.

Legislation also has been filed to force Medicare to pay for interpretation of electrocardiograms and to boost Medicare payments to new physicians.

On May 7, US Sen Lloyd Bentsen (D-Texas) filed S 2683, which would require the Health Care Financing Administration (HCFA) to update the GPCI a year earlier than under current law. It also authorizes the Health and Human Services (HHS) secretary to adjust the value assigned to an index in a fee schedule area because of unique local circumstances.

Also, the HHS secretary would be required to study and report to the Senate Finance Committee and House Ways and Means Committee no later than April 1, 1993, on data necessary to review and revise the GPCI, any limitation on availability of data necessary to review and revise such indices at least every 3 years, ways of addressing such limitations, and costs of developing more accurate and timely data sources. Senator Bentsen chairs the Senate Finance Committee.

Finally, the bill would require the Physician Payment Review Commission to study and report by July 1, 1993, on the feasibility and desirability of providing for a special adjustment to the index value of the medical equipment and suppliers input component regarding services.

"Senator Bentsen's bill tracks exactly the positions of the Texas Medical Association regarding problems with the geographic practice cost index," said Fred F. Castrow, MD, Houston, chairman of the TMA Council on Legislation. "We compliment the senator for his support of TMA on the need for correcting the GPCI."

Also filed May 7 was S 2680 by Sen David Pryor (D-Arkansas). The bill is identical to HR 4393, the Medicare Geographic Data Accuracy Act of 1992, which was filed March 5 by US Rep Ralph Hall (D-Rockwall). Several other Texas congressmen have signed on as cosponsors for the TMA-supported bill.

It would require HCFA to use "the most recent available data" when calculating the GPCI. It also would require HCFA to work with each state medical society, or another organization that represents the majority of practicing physicians in a state, in revising the GPCI. The measure would take effect January 1, 1993.

Problems with the GPCI include basing office rent costs on a 1987 US Department of Housing and Urban Development study of suburban apartment rents, basing employee wages on a 20% sampling of clerical workers and nurses from the 1980 census, and basing physician work on 1980 census data on average hourly earnings of nonphysician professionals, such as teachers and engineers.

> "SENATOR BENTSEN'S BILL TRACKS EXACTLY THE POSITIONS OF THE TEXAS MEDICAL ASSOCIATION REGARDING PROBLEMS WITH THE GEOGRAPHIC PRACTICE COST INDEX."

Medical liability costs for the Texas GPCI are based on information from a company that insures only a few hundred of the state's 30,000-plus practicing physicians.

The EKG Payment Restoration Act was filed by US Rep Tom McMillen (D-Maryland) and has more than 200 cosponsors. It repeals Medicare's ban on payment for interpretations by consulting physicians.

Two bills have been filed to correct inequitable Medicare payments to new physicians during their first 5 years of practice. Under the new Medicare fee schedule, new physicians are paid 20% less than the normal per service fee during their first year of practice, 15% less the second year, 10% less the third year, and 5% less the fourth.

HR 1898 by US Rep Ed Towns (D-New York) would repeal that system, but does not conform to the "pay as you go" provisions in the 1990 budget agreement. A second bill, filed by Representative Towns and US Sen John McCain (R-Arizona) is budget-neutral and would require reductions in aggregate Medicare payments to offset the increases for new physicians.

Along with correcting GPCI problems, both the EKG and new physician payments are among TMA's Medicare priorities for 1992.

Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs section of* Texas Medicine.

OREGON OFFICIAL TO OVERSEE TEXAS HEALTH AND HUMAN SERVICES AGENCIES

AFTER CONSIDERABLE DELAY, the coordination of services offered by 11 state health and human services agencies is about to get under way with the appointment of Richard C. Ladd of Oregon as the first Texas commissioner of health and human services.

Governor Ann Richards announced Mr Ladd's appointment May 19. Mr Ladd was to assume his post June 15. The governor named Kathleen Hamilton, head of the transition team working to create the new Health and Human Services Commission, to serve as acting commissioner until then.

"Dick Ladd will bring to Texas an impressive background in coordinating the activities of large state agencies that provide services as diverse as administering the food stamp program to providing measles shots to school children," Governor Richards said. "Mr Ladd's work in Oregon makes him uniquely qualified to take on the tremendous responsibilities of his job in Texas."

The Health and Human Services Commission was created by the Texas Legislature in 1991. As health and human services commissioner, Mr Ladd will oversee the coordination of services among the Texas departments of health, human services, and mental health and mental retardation, as well as several smaller agencies. Those agencies have a combined budget of more than $18 billion and more than 57,000 employees. He also has been charged with setting up one-stop social services centers in the state's counties.

Prior to his Texas appointment, Mr Ladd served as assistant director of the Oregon Department of Human Resources. In that job, he was responsible for consolidation of Oregon's health and human services agencies into one agency.

"The new Health and Human Services Commission will have a profound effect on the delivery of services in Texas," said Frederick L. Merian, MD, Yoakum, chairman of Texas Medical Association's Council on Socioeconomics. "TMA is pleased that the governor has appointed someone with Mr Ladd's depth of experience to lead this agency. We look forward to working with him as he begins the task of improving state health and social services."

Mr Ladd, 53, has been described as tough, controversial, and an advocate of the consumer of health and human services.

After serving in the US Navy and working as a truck driver, he returned to college at age 33, earning a degree in experimental psychology from Oregon State University. He joined the Oregon Department of Human Resources upon graduation in 1976.

Mr Ladd has been active in the area of long-term care services reform. He has served on committees of the US Department of Health and Human Services, the National Association of State Units on Aging, the American Public Welfare Association, the American Association of Retired Persons, and the National Governors' Association.

Other agencies included under the new commissioner's umbrella include the Department on Aging, Commission on Alcohol and Drug Abuse, Commission for the Blind, Commission for the Deaf and Hearing Impaired, Interagency Council on Early Childhood Intervention Services, Texas Rehabilitation Commission, Texas Youth Commission, and Juvenile Probation Commission.

TMA delegates act on tax credits, drunken driving, other legislative issues

PROVIDING INCOME TAX credits for payment of health insurance premiums and lowering the legal intoxication level for drunken driving are among issues the Texas Medical Association Council on Legislation will examine as a result of House of Delegates action.

These and other issues were referred to the Council on Legislation at the May 15 meeting of the House of Delegates in San Antonio.

Delegates directed both the councils on legislation and socioeconomics to study a Navarro County Medical Society resolution supporting income tax credits as a means of financing health-care reform. The proposal calls for health insurance benefits to be part of gross wages, with refundable tax credits for low-income families. The resolution also calls for tax credits for deposits to "Medisave" accounts that would provide health coverage for the elderly.

The councils are to report back to the House of Delegates in November.

Also referred to the councils on legislation and socioeconomics was a Bexar County Medical Society resolution to support HR 4280 by US Rep John Rhodes (R-Arizona). The bill would create tax-deductible medical savings accounts for individuals not covered by employer-provided insurance.

On the issue of drunken driving, delegates approved and referred to the Council on Legislation a resolution from the Harris County Medical Society seeking passage of legislation to reduce alcohol-related vehicle deaths. Among measures sought is the lowering of the legal limit for intoxication from a blood alcohol concentration of 0.10% to 0.08%; loss of a driver's license within 30 days of conviction for driving while intoxicated; use of sobriety check points; providing a distinctive driver's license for those under age 21; and financing drunken driving prevention programs with a portion of traffic fines and penalties from drunken driving offenses.

In other legislative actions, the House of Delegates:

- Approved a recommendation to

seek legislative initiatives to strengthen existing regional medical telecommunications systems in Texas.

- Approved and referred to the councils on legislation and member services support for initiatives to provide legislative authority for medical schools, health science centers, and other health-related institutions to provide affordable health and disability insurance for medical, nursing, and allied health students.
- Approved a recommendation from the Physician-Patient Advocacy Committee to seek legislation increasing the portion of physician licensure fees allocated for the operation of the Texas State Board of Medical Examiners (TSBME). Currently, only 62% of such fees goes to the board.
- Referred to the Council on Legislation and Hospital Medical Staff Section a Harris County Medical Society resolution seeking legislation to require the TSBME to review and issue an opinion on any allegation of restraint of trade made by a physician denied hospital medical staff privileges prior to initiation of legal action by the physician against a hospital, its medical staff, or members of its committees.
- Referred to the Committee on Professional Liability a Bexar County resolution seeking legislation to provide liability protection to physicians providing free care, regardless of where it is provided.
- Asked the Council on Legislation to initiate state legislation to make lead poisoning a reportable disease.

Voters blame malpractice suits for high cost of health care

SEVENTY-FIVE PERCENT OF Texas voters believe high health-care costs are the result of the number of expensive malpractice suits filed against physicians.

That is the result of a survey conducted in March by Shipley and Associates of Austin Inc. The survey also found that 72% of Texans agreed high insurance premiums force doctors to charge more for their services. Seventy-five percent of respondents said they favor setting a cap on jury awards in malpractice lawsuits.

The survey was conducted between March 18 and 23. It questioned 603 Texas voters and is accurate to within plus or minus 4% at a 95% confidence level.

The results were presented to the TMA Health Policy Advisory Panel at a May 14 meeting in San Antonio. The advisory panel, chaired by Max C. Butler, MD, Houston, was created to assist the division of public affairs staff in monitoring activities and recommendations of the Texas Health Policy Task Force.

Other survey questions showed 78% of respondents would visit only a medical doctor as opposed to any other nonphysician. Only 7% said they would visit a chiropractor in order to save money, 7% said they would visit a nurse, 2% said other nonphysician, and 1% said midwife.

All articles in Texas Medicine *that mention Texas Medical Association's stance on state legislation are defined as "legislative advertising," according to Tex Govt Code Ann §305.027. That law requires disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in* Texas Medicine: *Robert G. Mickey, Executive Vice President, TMA, 401 W 15th St, Austin, TX 78701.*

Houston physician named to cancer council

J. TAYLOR WHARTON, MD, Houston, has been appointed to the Texas Cancer Council by House Speaker Gib Lewis.

Dr Wharton was named to a 6-year term on the council. He is chairman of the gynecology department at The University of Texas M.D. Anderson Cancer Center and a nationally recognized authority on gynecological cancers.

Dr Wharton is the second physician and TMA member appointed to the 16-member council recently. Courtney M. Townsend Jr, MD, of The University of Texas Medical Branch at Galveston, was appointed to the panel in March by Lt Gov Bob Bullock. ★

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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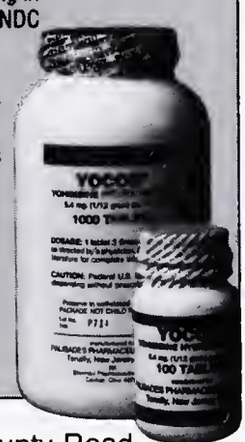

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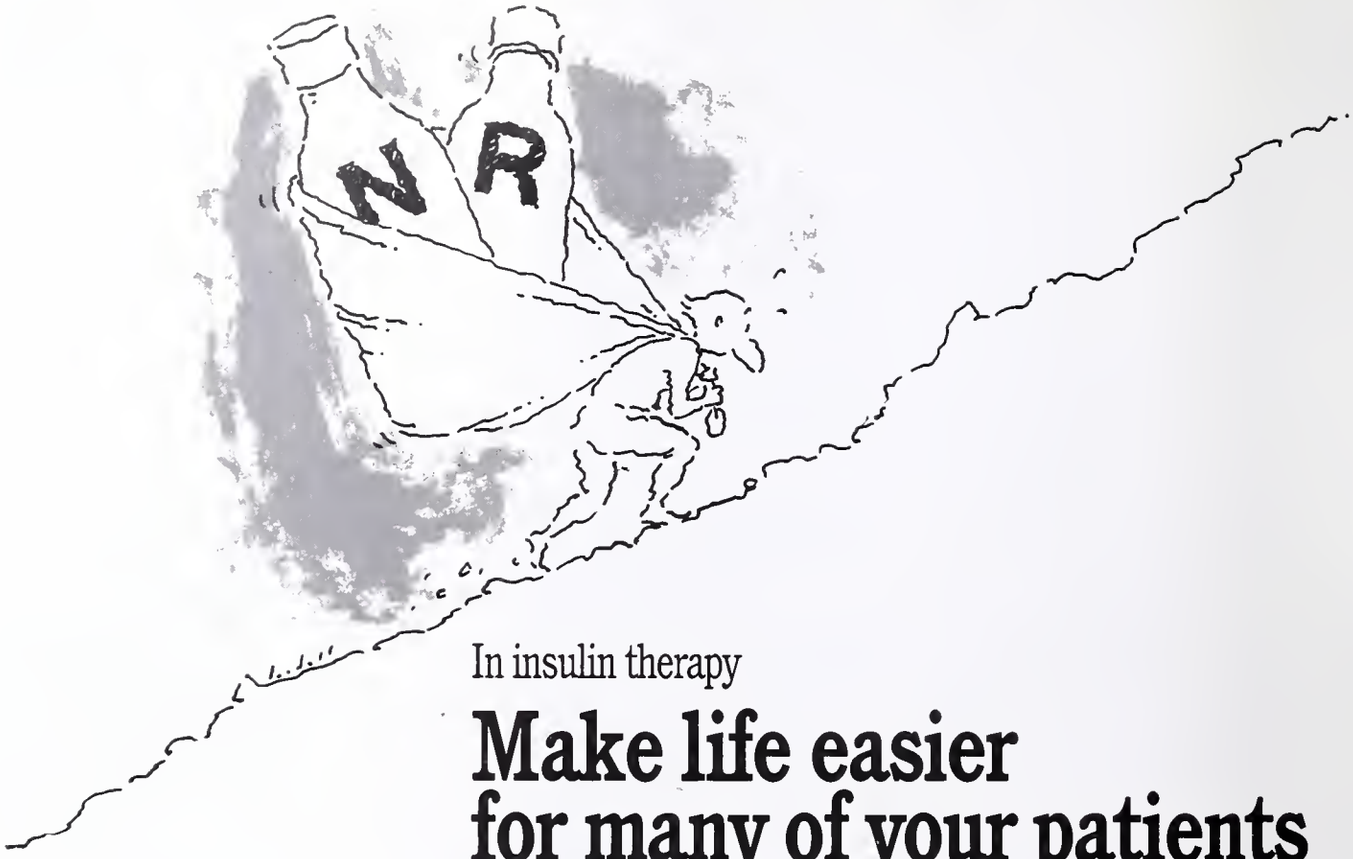

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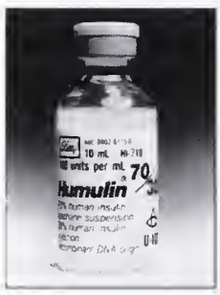

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Science and Education

TMA House grapples with CME, licensure issues

THE TEXAS MEDICAL Association House of Delegates voted to send a strong message to the federal government to let medicine keep its own house in order when it comes to regulating continuing medical education (CME).

The delegates approved a recommendation from the Council on Medical Education at TMA's 125th Annual Session May 15 in San Antonio to oppose a concept paper developed by the federal Food and Drug Administration critical of the current state of pharmaceutical support of CME and proposing federal regulation of promotional activities that occur in scientific or educational contexts. The delegates also approved several other recommendations regarding limits on the government's ability to intervene in the educational and scientific process.

The FDA paper, "Drug Company Supported Activities in Scientific or Educational Context," attempts to define which drug company activities fall under the FDA's regulation of promotional activities by drug companies and which activities are purely informational. The TMA council believes the paper, if implemented as regulation, would curtail the exchange of scientific and educational information rather than curtail the promotional activities of pharmaceutical companies.

The delegates approved recommendations that oppose further promulgation of the concept paper and its proposed regulations; oppose further steps that would lead to inappropriate intervention of the FDA by enforcing proposed regulations; oppose differentiation between medical schools, commercial CME firms, or other entities when enforcing high standards for CME activities; and oppose inappropriate federal intervention in the educational and scientific process. The delegates voted to communicate to the FDA its opposition to the concept paper.

A spokesman for the FDA in Washington said shortly after the vote by the delegates that the paper and comments received regarding it were "still under study" by the agency, and no action was expected "for several months." He declined to speculate on what action might be taken in regard to the paper's proposed regulations.

In other action on medical education topics, the House of Delegates voted to:

- Emphasize TMA's support for establishing national uniform standards for CME credits, definitions, and terminology, and to communicate that support to the AMA House of Delegates and task force. The TMA delegates referred a proposed definition of CME to the Council on Medical Education for further study.
- Voice opposition to the "CME Learning Assessment Form" (CLAF) distributed by the American Hospital Association and the American Medical Association, based on several problems with the form, primarily due to a lack of instructions outlining the appropriate use of the form, the added paperwork it would bring, and the CME sponsor's difficulty in assessing participants' acquisition and retention of cognitive and procedural skills. The delegates voted to acknowledge the need for hospital credentialing committees to obtain appropriate and detailed information on the nature of physicians' education and to appoint an ad hoc committee to develop recommendations for more appropriate methods of accomplishing the intended objectives of the CLAF.
- Continue to study the issue of mandatory CME as a basis for relicensure. The delegates, after much debate, also voted to refer a recommendation regarding TMA's current policy on voluntary CME to the Councils on Medical Education and Legislation, which will report to the TMA Board of Trustees in September. The delegates also approved a number of recommendations for improvements in CME contained in an extensive position paper presented to the House.
- Supported the use of a single examination for the initial licensing of physicians in Texas, supported the use of the United States Medical Licensing Exam for the initial licensure of physicians in Texas, supported the promulgation of rules by the Texas State Board of Medical Examiners to establish a single pathway for initial licensure, and charged the Council on Medical Education with studying the impact of requiring one licensing examination for applicants for initial licensure and licensure by reciprocal endorsement.
- Referred to the Council on Medical Education a resolution by the DeWitt-Lavaca County Medical Society encouraging Texas' medical schools to choose students likely to go into primary care and to set as a goal having 50% of their graduating medical students choose primary care residencies.

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

El Paso hospital to participate in cardiovascular study

Providence Memorial Hospital, El Paso — The Cleveland Clinic Foundation and Duke University Medical Center have chosen Providence Memorial Hospital to participate in the largest US-based cardiovascular study ever conducted. The study, Global Utilization of Streptokinase and tPA for Occluded Coronary Arteries (GUSTO), will involve 41,000 patients in 1,200 hospitals worldwide to evaluate and compare the effectiveness of thrombolytic agents in treating heart attack victims. Providence Memorial is providing nursing and pharmacy support to the GUSTO study in the El Paso area.

UTMB incorporates ethics course into curriculum

The University of Texas Medical Branch, Galveston — A unique study of medical ethics is being introduced to medical students. "Ethics of Scientific Research" is a class that uses intense workshops and small, interactive groups to immerse students into the topic of scientific integrity. The new course meets the National Institutes of Health requirement that institutions applying for training grants establish an ethics program. In the UTMB course, rather than simply lecture students on ethics, instructors divide the class into small groups to discuss actual cases of ethical misconduct. A forum of the university's senior scientists describe their personal experiences and perspectives on the interplay between ethics and the practice of science. The course will be offered to third- and fourth-year students beginning in 1993.

World's first dermatologic tissue bank to search for psoriasis gene

The University of Texas Southwestern Medical Center/Baylor University Medical Center, Dallas — Researchers in Dallas are starting the world's first tissue bank to study psoriasis, which they hope will lead to the discovery of the gene or genes responsible for the disease that afflicts more than 4 million Americans. In a unique cooperation project, researchers at UT Southwestern and Baylor University Medical Centers received the grant from the National Psoriasis Foundation to create the bank. Through the study, scientists hope to identify a specific gene that causes the affliction and learn how the genes turn on and off and how they are regulated.

Information for this column comes from a variety of sources, including academic institutions, state and federal agencies, and private institutions. We welcome submission of items of interest. Send them to Texas Medicine, *Science and Education Editor, 401 W 15th St, Austin, TX 78701.*

TMA honors trio with Excellence in Science Teaching awards

TODAY'S STUDENTS ARE tomorrow's physicians, but only if teachers can capture their imagination and encourage them to pursue careers in science. The Texas Medical Association each year honors such teachers at its annual session, and this year TMA presented its Award for Excellence in Science Teaching to three Houston area teachers.

Robert Dennison of Jersey Village High School, Melinda Mills of Clear Lake Intermediate School, and Jane C. Hill of Northside Elementary School in Angleton were honored during the annual membership luncheon at TMA's annual meeting May 16 in San Antonio. Six other Texas science teachers were selected to receive awards of merit.

The TMA Award for Excellence in Science Teaching was established in 1990 as part of an effort to address a growing crisis in science education and the long-term effects that science illiteracy poses for the health and well-being of Texans. Winners receive a $1,000 cash award. The competition was expanded this year to recognize teachers at elementary, middle/junior high, and high school levels.

Mr Dennison, who teaches biology, anatomy, and physiology at Jersey Village High School, has been teaching for 14 years. He received his bachelor's degree in biology and master's degree in education from the University of Houston. He was named Teacher of the Year by the Houston Teachers Association for 1985–1986. He also was named a Distinguished Teacher by the White House Commission on Presidential Scholars for 1986–1987.

Ms Mills, an 18-year classroom veteran, teaches regular and advanced life science courses for seventh graders at Clear Lake Intermediate School in Houston. She holds bachelor's and master's degrees in biology from Austin Peay State University in Clarksville, Tenn. Ms Mills has taught in public schools in Tennessee and Ohio, as well as at St John's College in Cambridge, England. She won an award of merit in the TMA competition in 1990 and was named Outstanding Science Teacher at the Greater Houston Science and Engineering Fair in 1990. She also received the National Science Teachers Association Gustav Ohaus Middle School National Award for Creative and Innovative Teaching in 1990.

Ms Hill teaches fifth-grade general science at Northside Elementary School in Angleton. She holds a bachelor's degree from The University of Texas at Austin and a master's degree in education from the University of Houston. Ms Hill has 9 years of experience teaching in public schools in the Houston area.

Award of merit winners include Jo Anna Harrison, a fifth-grade science teacher at J.P. Cornelius

TMA's Award for Excellence in Science Teaching was presented by John W. Burnside, MD, (left) chairman of the Council on Scientific Affairs, at the TMA Annual Session. Recipients are Melinda Mills of Clear Lake, Robert Dennison of Houston, and Jane C. Hill of Angleton.

Math/Science Academy in Houston; Priscilla Promise, a fourth-grade science and health teacher at B.M. Pope Elementary School in Arlington; Linda A. Pruski, a seventh-grade life science teacher at Anson Jones Middle School in San Antonio; Alice Kagi, a biology teacher at St John's School in Houston; Alton L. Biggs, a biology teacher at Allen High School; and Leyla A. Cohlmia, a chemistry teacher at Austin High School in Austin.

Texas institutions participate in Breast Cancer Prevention Trial

EACH DAY, THOUSANDS OF women take a hormone drug in an effort to prevent recurrence of their breast cancer. Now researchers across the United States and Canada — including four sites in Texas — are studying whether the same drug, tamoxifen, can prevent breast cancer in women with no history of the disease. In addition, the study will determine if mortality attributed to breast cancer is reduced.

Texas participants in the Breast Cancer Prevention Trial are The University of Texas Health Science Center in San Antonio, the Charles A. Sammons Cancer Center at Baylor Medical Center in Dallas, Scott and White Memorial Hospital and Clinic in Temple, and UT's M.D. Anderson Cancer Center in Houston. The study is being conducted by the National Surgical Adjuvant Breast and Bowel Project and is sponsored by the National Cancer Institute (NCI).

"According to the National Cancer Institute, about 1.5 million women will be diagnosed with breast cancer, and almost half a million will die of the disease over the next 10 years," said Victor Vogel, MD, assistant professor of medicine and epidemiology at M.D. Anderson. "It's terribly important that women around the country have this opportunity to take part in a massive clinical study to help researchers assess the preventative benefits of tamoxifen."

The 5-year study will involve 16,000 women aged 35 and older. Only women who are at increased risk for breast cancer will be included in the study. Women 60 years and older will be eligible based on age alone; women between 35 and 59 must have a risk of breast cancer equal to or greater than a 60-year-old.

"This is one of the most important studies ever launched," said Anatolio Cruz, MD, principal investigator for UTHSC-SA. "We're going to identify women who are at high risk to develop breast cancer. Once we've done this, we'll register them and put their profiles in the computer so we can follow them."

The women participating in the double-blind study will receive two 10 mg tamoxifen pills (or a placebo) daily for 5 years, with follow-up examinations for another 5 years.

Researchers at NCI reported a "vigorous" initial response to the announcement of the project. More than 4,000 phone calls were received on a toll-free number providing information about the study during the first 36 hours after the announcement.

TMF presents education conference

TEXAS MEDICAL FOUNDATION'S 1992 education conference, "Total Quality Improvement," will be held July 11 at the Stouffer Austin Hotel, from 9 am to 1:30 pm. The conference is geared toward physicians, professional nurses, administrators, utilization/quality assurance/medical record professionals, and other health-care professionals involved in assuring quality medical care.

The registration fee is $50 per participant, but all TMF physician members may attend free.

For additional information or to register, contact Martha Morse, RN, at TMF, 901 Mopac Expressway South, Suite 200, Austin, TX 78746, (800) 725-9216 or 329-6610 in Austin. ★

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Medical Economics

Improvements in Medicaid program make it easier to participate

NOT LONG AGO, WHEN THE subject of Medicaid came up, many physicians cringed, but not because they objected to caring for the indigent citizens of Texas. Far from it — statistics show that Texas physicians are among the most generous in the nation in terms of the amount of charity care given each year.

But when it came to dealing with Texas' Medicaid program, the headaches and hassles often far outweighed the satisfaction of caring for those most in need. There were seemingly endless regulations, exacting paperwork, and rejected claims that cost more money to appeal than could be recovered. Reimbursement levels were often considerably below the physician's cost of providing the service, and many had no choice but to close their doors to new Medicaid patients to stop their practices from going broke.

But Medicaid has changed in Texas, and many TMA physician leaders believe it is time to take another look at participating in the program.

"We (physicians) should all do our share in regards to seeing Medicaid patients," said TMA President William G. Gamel, MD. "If we all shared a part of the burden, it would be easier for the system and easier for those who participate."

One of the biggest changes in the Medicaid program occurred on April 1 of this year when the Texas Department of Human Services (TDHS) instituted a modified resource-based relative value scale (RBRVS) payment system for Medicaid, boosting payments to primary care physicians while trimming fees for some surgery and other procedures.

Another compelling reason to take another look at Medicaid, say physician leaders, is the dramatic growth in the population now eligible for Medicaid. In the last 4 years, the eligible population has doubled from 750,000 to 1.5 million Texans, comprising 9% of the state's population.

During that same period (1988–1992), the proportion of Medicaid patients has grown from 5% to 13% of the average physician's practice.

"For the burden of Medicaid to fall on a few, I think, is unfair," said Dr Gamel. "Sometimes geography and demographics mandate that, but I think we all should pitch in and do a part of Medicaid. I think we have a duty to perform public service."

According to state officials, the profile of the average Medicaid recipient has changed. Most people eligible for Medicaid are not on welfare, but are the "working poor," those people with jobs who live above the poverty line but do not make enough to afford adequate health insurance.

Nearly 75% of Medicaid recipients are children and pregnant women. In expanding eligibility for the program, both the state and federal governments recognized that childhood and the prenatal period represent critical times for providing health care that is extremely cost-effective over the long term.

"It's an honor to practice medicine, not a right," said Don Kelly, MD, an Austin cardiovascular surgeon who heads the Texas Medicaid program. "We owe our predecessors and society the respect of taking care of the sick and the poor."

TMA has worked through direct contact with the Texas Legislature and TDHS and active participation in the TDHS' Physicians' Payment Advisory Committee to bring about major changes in the Medicaid system to provide better access to care for Texans and to make the reimbursement system better and more hassle-free.

> MEDICAID HAS CHANGED IN TEXAS, AND MANY TMA PHYSICIAN LEADERS BELIEVE IT IS TIME TO TAKE ANOTHER LOOK AT PARTICIPATING IN THE PROGRAM.

"Though it is far from perfect, major changes in the Medicaid program have made it much less of a hassle to participate," said Mike Dabbs, TMA director of quality assurance and utilization review. "Medicaid also offers an important opportunity to expand one's medical practice to the less fortunate in Texas with less hassle and risk than ever before."

To assist physicians who wish to join or rejoin the Medicaid program, TMA is publishing a comprehensive booklet titled "Medicaid — Take Another Look." The booklet provides an in-depth profile of the changes in the system and provides instructions for enrollment, participation, and claims.

The booklet, available this month, costs $59 for TMA members, $120 for nonmembers. To order your copy, write to "Medicaid — Take Another Look," TMA Practice Management Department, 401 W 15th St, Austin, TX 78701.

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

Delegates oppose HCFA regional clinical data abstraction proposal

SAYING THERE IS NO NEED for another layer of federal bureaucracy for physicians to have to deal with, the Texas Medical Association House of Delegates strongly voiced its objections to a proposed system of regional clinical data abstraction centers (CDACs) that would house a government data bank containing information from medical records.

Among physicians' concerns about the CDACs are how to protect confidentiality of physicians' and patients' medical records, the use of practice parameters, and the use of inaccurate algorithms in the CDAC computer program. The CDAC program was proposed by the Health Care Financing Administration (HCFA) late last year.

The CDACs' proposed data base, called the Uniform Clinical Data Set (UCDS), will use a computerized system for reviewing and abstracting data from medical records that would lead to approval or referral of a case for physician review. On instructions from HCFA, peer review organizations (PROs) would be required to forward data on all cases selected to CDACs for UCDS review regardless of the findings of review. HCFA also would require that the attending physician be identified within the UCDS data.

Information obtained through the UCDS would be used by the CDACs to perform the abstracting function routinely carried out by peer review organizations across the country.

Opposition to the CDACs and the UCDS centered around several points, including:

- that the proposed computer system to be used in the CDACs has not been fully developed, and algorithms it will use in reviewing case parameters are not understood;
- that information in the system will be subject to the Freedom of Information and Privacy Acts, jeopardizing the confidentiality of patients' medical records; and
- that HCFA's method of proposing the CDACs, by publishing a "notice of a new system" rather than "notice of a proposed rule," is designed to circumvent the normal regulatory process and give the agency the ability to put the program into effect at any time.

Members voted unanimously to oppose the implementation of CDACs and the UCDS until its computer program is fully documented, its algorithms are understandable, confidentiality concerns are satisfactorily addressed, and the effect of practice parameters currently under development by specialty societies is fully evaluated.

The delegates also voted to ask the AMA to oppose the further implementation of regional clinical data abstraction centers and to pursue legislation, if necessary, to stop the implementation of CDACs and the UCDS.

A resolution on this topic was scheduled to be taken by the Texas delegation to the AMA House of Delegates in June.

In other action on socioeconomic topics, the delegates:

- Opposed the extension of the Resource Based Relative Value Scale (RBRVS) payment system to private payors until the system undergoes further refinement and its impact on care is better understood.
- Approved a resolution by Burton Crain, MD, Nacogdoches, calling for legally mandated formal physician involvement in all areas of legislative or regulatory generated health care policy development.
- Approved a substitute to a resolution by the El Paso County Medical Society calling for TMA to develop a rational, fair, and reasonable plan for an administrative system to adjudicate all medical liability claims possibly under the auspices of the Texas State Board of Medical Examiners. The delegates voted to present that plan to the Council on Legislation for review.
- Heard a recommendation from the Physician-Patient Advocacy Committee to work with the Texas Congressional Delegation to support legislation exempting a state from the federal anti-patient dumping law if the state has a comparable or superior hospital transfer law. The delegates referred the matter back to the committee for further study, but they approved a recommendation to form a task force of interested parties, such as the Texas Department of Health, Texas Hospital Association, and others, to develop recommendations for legislation.
- Approved an amended resolution from the Angelina County Medical Society that the TMA request the Health and Human Services Department to stop issuing deficiency reports to nursing homes based on disagreement with a medical regimen and that allegations of any such deficiencies be referred to the state peer review organization.

TMA endorsement of TMLT forges new working relationship

THE TEXAS MEDICAL Association Board of Directors has endorsed the Texas Medical Liability Trust and approved a broad array of TMA-TMLT working relationships and financial agreements.

The endorsement and working relationship between TMA and TMLT is the result of more than a year of discussions between the two organizations, according to TMLT President Sam Branham.

"It's been a long time coming," he said. "It's been one of the things that (TMA Executive Vice President) Bob Mickey and I have worked diligently on since last year. The bottom line is that it's going to benefit the doctors in the state of Texas."

The working agreement will include joint sponsorship of risk management seminars, membership communication services, and legislative and regulatory affairs programs.

"TMA and TMLT share many common goals, and this new relationship will be a major benefit to TMA members," said Robert G, Mickey, TMA's executive vice president. "The TMA board feels that working with TMLT will provide physicians better access to risk management information and may also strengthen medicine's voice in the legislature."

Mr Branham agrees that the combined strength will be a real advantage.

"TMA has excellent people and excellent departments," Mr Branham said. "I think coordinating the activities of TMA with TMLT and the data that we have relative to our base of policyholders in the state and our experience over the past 13 years will give both of us a tremendous ability to move forward on issues such as tort reform and risk management issues."

> "TMA AND TMLT SHARE MANY COMMON GOALS, AND THIS NEW RELATIONSHIP WILL BE A MAJOR BENEFIT TO TMA MEMBERS."

The TMLT was created in 1978 by TMA in the midst of a liability insurance crisis in which rates were skyrocketing and the availability of medical liability coverage was in jeopardy. TMLT's board of directors is made up of TMA members, but operates independently of TMA.

Daniel Chester, MD, McAllen, chairman of the TMLT board of directors, said cooperation will be the key element of a successful working relationship.

"A close cooperation between TMA and TMLT has a number of benefits for TMLT," he said. "These benefits include access to TMA's legislative expertise, the efficiency of cosponsoring workshops, and the introduction of TMLT products and services to new TMA members."

The trust was created to provide continued availability of professional liability coverage to TMA members, provide that coverage in the most cost-effective method possible, and insure that risk would be allocated among physicians as equitably as possible.

"We are here for the doctors in Texas; TMA is here for the doctors in Texas, so it's a hand-in-glove fit. We both have the same purposes in life," Mr Branham said. "The more doctors that we can insure, with good experience, that can produce good results and strengthen the financial base of TMLT, then — over the long term — the more stable the medical malpractice market will become in Texas for doctors."

Mr Branham noted that TMLT was created to fill a special role for Texas physicians.

"It's not that we want to grow and become the biggest," he said. "We believe we're the best and we want to remain the best. If we're the best, then we'll get our fair share of the market . . . ."

Mr Mickey said that serving members is the key to the new relationship.

"Our job is to provide the best possible products and services we can for TMA members," he said. "This endorsement and new working relationship is an important step forward in that direction."

TMA persists in struggle to ease 'regulatory overload'

ASK ALMOST ANY PHYSICIAN and he or she will tell you there has never been a year like 1992. And they don't want to see another one like it.

The 1992 alphabet soup alone will set your head spinning: RBRVS, OSHA, ADA, UPINs, CLIA, HCFA-1500. Numerous and complex government programs have been implemented that affect every practicing physician and their staff. It all adds up to a year of regulatory overload, says Louis Goodman, PhD, TMA di-

Inspector General Kusserow resigns

REPORTS AT TEXAS MEDICINE'S press time said Richard Kusserow, the controversial inspector general of the Health and Human Services Department, has resigned that post to pursue a career in the private sector.

Mr Kusserow, appointed in 1981 by President Reagan, had incurred the wrath of groups such as the American Medical Association, American Hospital Association, and Texas Medical Association, who called for his resignation in 1990 because of his aggressive, confrontational approach towards investigating allegations of physician misconduct. Organized medicine had been particularly critical of his "bounty hunter" approach to sanctions, which rewarded enforcement officers and removed physicians from Medicare and Medicaid, leaving poor and elderly patients without care.

A successor was not immediately named.

rector of medical economics.

"TMA staff has been working full-speed-ahead to assist physicians in coping with the changes coming at them this year," says Dr Goodman. "TMA's goals are to fight intrusive, unreasonable regulations, and when regulations are being implemented, to function as a resource for clear, useful information that can help physicians and their office staff meet the new requirements with a minimum of stress."

Thus far in 1992, TMA has initiated several programs to cope with new regulations. Among them are:

"OUR STAFF HAS BEEN WORKING FULL-SPEED-AHEAD TO ASSIST PHYSICIANS IN COPING WITH THE CHANGES COMING AT THEM THIS YEAR."

- The Medicare RBRVS Action Plan, designed to assist physicians in dealing with the new, complex payment structure and to rectify some of the problems with the system. TMA published "The Coding Tree," and is preparing an updated edition of "The Medicare Maze," instituted a statewide series of workshops on the Medicare payment system, and has hired additional staff to consult with physicians over Medicare problems. TMA also has worked with the Texas congressional delegation to introduce legislation to correct several flaws in the payment system, particularly the flawed numbers in the GPCIs, and continues to seek regulatory relief for others.

- For the new Occupational and Health Safety Administration (OSHA) rules, TMA offered a series of workshops and a comprehensive manual to help physicians understand and comply with the regulations.

- TMA's action plan for the new Clinical Laboratory Improvement Amendments (CLIA) includes a package of information for physicians with office labs to assist them in meeting deadlines and complying with the regulations. TMA also participated in a major push last year to change several proposed regulations that would have been a hardship for physicians.

- TMA has worked with the state Medicaid program (see story, page 58) to improve the payment system and increase access to care for the state's poor.

- TMA offers, in conjunction with county medical societies, "Mini-Medicare consultations" to help physicians deal with the nuts-and-bolts issues of Medicare claims.

- TMA's Managed Care Review is a series of meetings between TMA staff and physicians and managed care insurance carriers to help clear up physicians' hassles.

TMA's medical economics staff continues to assist physicians with the avalanche of regulations.

"The government's assumption seems to be that every physician has working in his or her office a full-time attorney, a full-time accountant, and a full-time computer manager who can almost instantly adapt to any change," said Dr Goodman. "The reality is very different. These regulations place a great burden on the average physician's ability to practice medicine."

For more information on how TMA's medical economics staff can assist you in dealing with government programs or regulations, contact them at (800) 880-1300 or (512) 370-1414. ★

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

An outpatient-focused program for childhood diabetes: design, implementation, and effectiveness

PHILLIP D.K. LEE, MD

Treatment of childhood diabetes mellitus has undergone many recent changes, one of which is an increasing focus on outpatient management. In mid-1988, the pediatric diabetes clinic at Texas Children's Hospital began adopting an outpatient-focused treatment program using a care team. This report reviews our experience during this transition. Between 1987 and 1990, the percentage of new-onset patients who were never admitted to the hospital increased from 0 to 38%. Length of stay for new-onset patients who are admitted has declined. The shift in program focus has also led to decreased diabetes-related readmissions and length of stay per readmission. Estimated total patient cost savings exceed $100,000 per year for new-onset patients alone. Our results regarding patient care and cost-effectiveness agree with reports from other such diabetes treatment programs and support greater acceptance and use of this outpatient-focused approach.

Dr Lee, assistant professor, Department of Pediatrics, Baylor College of Medicine; acting chief, Texas Children's Hospital Diabetes Care Center. Send reprint requests to Dr Lee, Texas Children's Hospital, MC-3-2351, 6621 Fannin St, Houston, TX 77030-2399.

DELIVERY OF HEALTH CARE for children with diabetes mellitus has undergone major modifications over the past 10 years. Increasing evidence that the risk for long-term diabetic complications is related directly to high levels of blood glucose has led to a therapeutic emphasis on close, daily monitoring of blood glucose levels and careful attention to insulin dosage, meals, and exercise patterns. These components of care require that newly diagnosed children and/or their family members rapidly acquire knowledge and self-care skills for home management. Furthermore, the regimen for home treatment must be continuously and frequently modified for the individual needs of the growing child.

The process of transferring knowledge and management skills to newly diagnosed children and their families has traditionally centered upon an inpatient approach (1,2). A traditional program involves a 5- to 10-day hospitalization at the time of diagnosis, during which most management tasks are handled by the nursing staff. Knowledge and skills are transferred gradually to the patient and/or family prior to discharge.

Recently, several pediatric diabetes centers have adopted an outpatient approach in which new patients/families acquire basic, diabetes-related knowledge and skills within 1 or 2 days of diagnosis. Hospitalization occurs only if medically indicated, eg, for acute management of severe diabetic ketoacidosis, and the remainder of the treatment program is delivered in an outpatient setting. Limited data suggest that this approach may improve psychosocial adjustment and may result in both short- and long-term savings in cost.

The diabetes treatment program at Texas Children's Hospital has changed its focus to emphasize outpatient care over the past few years. The pediatric endocrinology and metabolism section assumed responsibility for the care of children with diabetes mellitus in 1986. Until mid-1988, all children with new diagnoses of diabetes mellitus were treated as inpatients. The shift to an outpatient-focused program was initiated in mid-1988 and accelerated beginning in mid-1989. A review of the program during this transition demonstrates that an outpatient-focused approach to new-onset insulin-dependent diabetes mellitus (IDDM) is both beneficial for patient care and cost-effective.

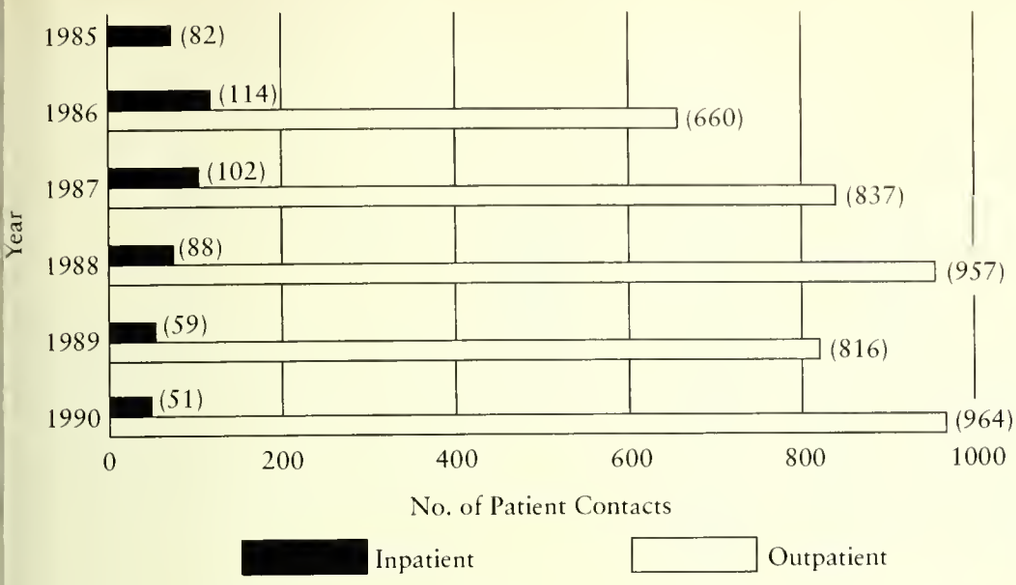
METHODS

All inpatient and outpatient records for pediatric patients with diabetes mellitus seen at Texas Children's Hospital between January 1, 1985, and December 31, 1990, were reviewed. For inpatient data, records having an ICD (International Classification of Diseases) code 250.xx (diabetes mellitus) were included. Admissions not related primarily to diabetes mellitus were excluded: eg, admissions for surgical procedures or treatment of cystic fibrosis. Outpatient data are reviewed for the years 1986 through 1990; data prior to 1986 are not available because patients for the diabetes clinic were not registered separately.

General description of the treatment program

The inpatient approach used before mid-1988 is mentioned above and has been described previously (2). The new outpatient-focused ap-

Fig 1. Total inpatient admissions and outpatient clinic visits by year.

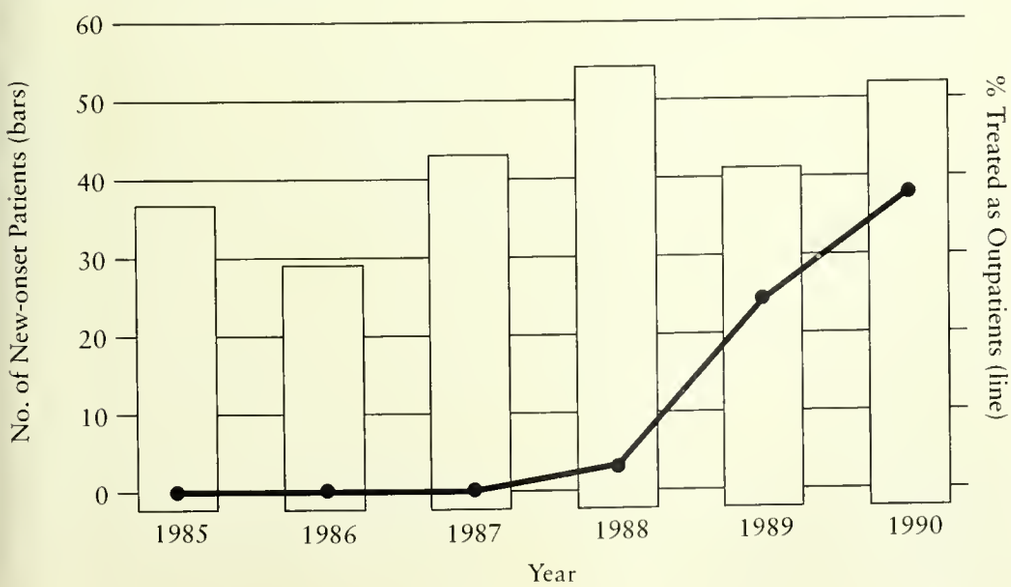


proach was designed using a team format including pediatric endocrinologists, two nurse-educators, a dietitian, and a social worker. New-onset patients are usually referred by their primary care physicians, and our initial medical evaluation is performed either in the outpatient clinic or in the emergency room, depending on the time of day and the clinical condition. Severely ill patients, including those with vomiting, severe dehydration, and changes in sensorium, are hospitalized for rehydration and initial insulin therapy. No specific laboratory criteria are used. After medical stabilization, the patient is usually transferred to an outpatient setting for treatment. Less ill patients may be treated entirely in an outpatient setting for either oral or intravenous hydration and subcutaneous insulin.

Treatment of each patient is supervised by an endocrinologist and coordinated by a diabetes nurse-educator. The initial sessions, usually lasting 8 to 12 hours over 2 to 3 days, are directed toward imparting a basic understanding of diabetes pathophysiology, insulin pharmacokinetics and administration, monitoring of blood glucose, treatment of hypoglycemia, and meal management. Psychosocial concerns are addressed by the clinic social worker. Educational materials are specifically designed to complement the outpatient program and are continuously reviewed and updated by members of the care team.

During outpatient follow-up visits 1 to 2 weeks and 1 month later, patients acquire additional knowledge and skills, and treatment effectiveness is assessed. Routine clinic visits are usually planned at 3- to 4-month intervals. Patients and/or parents are encouraged to call the diabetes nurse-educators for advice between visits. An endocrinologist is on call 24 hours daily.

Fig 2. New-onset patients by year. Bar graph (left y-axis) shows total numbers and line graph (right y-axis) shows percentages of new-onset patients who were treated as outpatients and never hospitalized.



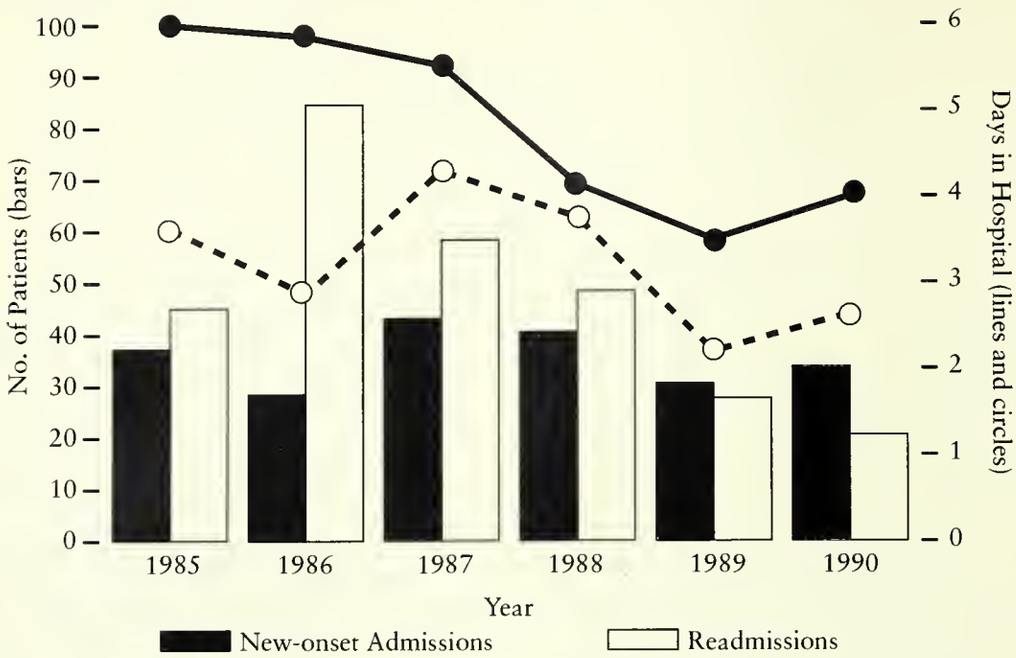
Results

Population Statistics

Fig 1 shows yearly totals for inpatient admissions and outpatient visits, including both new-onset and previously diagnosed patients. During 1986 through 1990, the percentage of inpatients with diabetes mellitus not followed in our clinic has ranged between 7.2% and 9.3% of the total diabetes-related admissions; these inpatients are not included in the data presented. As shown, total inpatient admissions decreased beginning in 1988, while outpatient visits have been relatively stable. The decrease in inpatient admissions began in mid-1988, coincident with the change in program emphasis; of the 88 total admissions, 56 (64%) occurred during the first half of 1988.

In Fig 2, new-onset patients per year are shown with the bar graphs. The percentage of new-onset patients who never required hospitalization is shown with the line graph. As shown, the total number of new-onset patients has been relatively constant, ranging from about 30 to 50 cases per year, while the percentage of new-onset patients never hospitalized has increased from 0 before 1988 to 38% in 1990. New-onset

Fig 3. Total numbers of inpatients (left y-axis) and average (mean±SE) length of stay (right y-axis) for new-onset admissions and readmissions by year.



patients ranged in age from less than 1 to 18 years at the time of diagnosis, and all but one patient included in this review had insulin-dependent diabetes mellitus. The single exception was a child with non-insulin-dependent diabetes mellitus.

Patient days

Fig 3 shows the number of inpatient days and average length of stay for new-onset patients and for previously treated patients admitted for diabetes-related problems. Total days and average length of stay have decreased significantly for both groups since 1988. For the new-onset patients, the inpatient number peaked at 42 in 1987 and declined to 32 in 1990, with average lengths of stay equal to 5.6±0.4 and 4.0±0.3 days (t-test, $P<.05$), respectively. For the previously treated patients, the case number peaked at 84 in 1986 and declined to 20 by 1990, with lengths of stay of 4.4±0.7 and 2.6±0.3 days ($P<.05$) in 1987 and 1990, respectively. The trend to shorter length of stay can be attributed directly to transfer of patient care to an outpatient setting following acute inpatient medical management for both groups.

Additional analysis was done to ascertain the cause for readmissions. Readmissions are defined as patients already receiving treatment for diabetes mellitus who are readmitted to the hospital for diabetes-related problems such as ketoacidosis and recurrent severe hypoglycemia. From January 1989 through December 1990, there were 36 readmissions. These 36 patients, representing approximately 10% of the total clinic population, accounted for 48 admissions and 113 patient days during this period. Of this group, 22 (61%) were admitted once, while 3 patients were admitted more than three times.

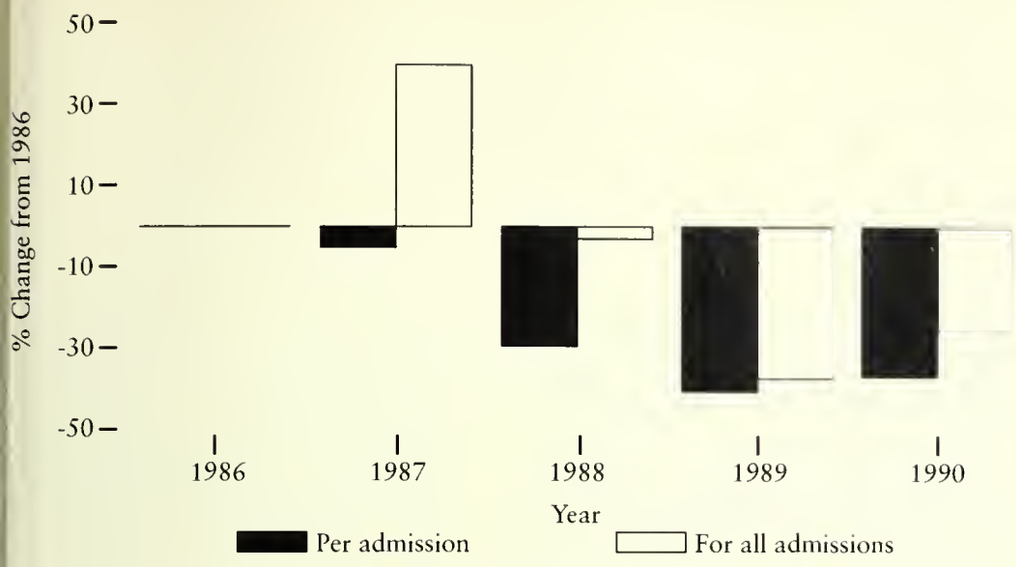
At the time diabetes mellitus was diagnosed in these 36 patients, 23 received their initial treatment as inpatients at Texas Children's Hospital, and the remaining 13 received their initial treatment as inpatients elsewhere. None had received the initial treatment in an outpatient setting. None of the 32 new-onset patients treated entirely in the outpatient clinic since mid-1988 have yet required hospitalization for diabetes-related problems. Indeed, since full implementation of the outpatient approach in 1989, only 1 new-onset patient (initially stabilized in the hospital) has required subsequent rehospitalization for diabetes-related problems.

To obtain a rough estimate of the cost-effectiveness of the outpatient focus, total hospital fees (excluding physician, nursing, and dietitian charges) were averaged for the last 23 consecutive new-onset patients who received initial treatment as inpatients. Average cost was $4,107.56±2,514.73 for a 3.96-day stay, or about $1,000/day. Referring back to the average patient days (Fig 3), the average cost per new-onset inpatient stay and total cost for all new-onset inpatients were estimated and compared to 1986 as shown in Fig 4. Although this estimate is based on the assumption that relative hospital costs have not changed between 1986 and 1990, the cost per new-onset inpatient and total annual costs for all new-onset inpatients appear to have decreased approximately 30% (more than $2000 per admission and more than $100,000 total) since the program's focus changed in 1988. This is probably a conservative estimate because additional physician charges are usually incurred during hospitalization. Moreover, this estimate does not include the increasing percentage of new-onset patients who are never admitted to the hospital (Fig 2). Referring back to Fig 3, we can estimate a similar trend in costs saved for previously diagnosed patients requiring hospitalization.

Discussion

An outpatient approach to diabetes care was first reported in 1953 by Walker (3), who detailed a program in Great Britain using a "health-visitor," an individual similar to our nurse-educator. Home and outpatient clinic visits were used to avoid hospitalization. Of the more than 7,000 patients followed, 19 were younger than 16 years old. Dr Walker was, perhaps, the first to note the beneficial effects of an outpatient approach for children:

Fig 4. Percentage changes in estimated costs for admissions of new-onset inpatients since 1986.



It is now our practice to undertake the entire management of these children in their own home unless they show severe ketosis. . . . In this way there is much less disturbance in the child's life at a time when everything seems against him. Education of the parents begins immediately, when they are most receptive, and they appreciate seeing for themselves the changes that occur during this phase. Their gratification leads to good management. (3)

Despite these encouraging results, nearly 30 years passed before other reports of outpatient programs to treat patients with diabetes appeared (4,5). In 1982, Whitehouse et al (5) reported an outpatient program for adults in Michigan. Of the 89 patients reported, 56 were "new to insulin." Results indicated an improved level of glycemic control was achieved through this approach. In addition, only 4 of the 89 patients required subsequent hospitalization, resulting in an estimated savings of 445 hospital days or about $90,000. The basic points and success of this program were reviewed in subsequent publications (6,7).

In 1983, Schneider (8) reported 52 children with new-onset IDDM treated with an outpatient approach at State University Hospital in Syracuse over an 8-year period. His comments regarding the benefits of this approach were almost identical to those of Walker, although follow-up data were not detailed. Subsequent reports from Great Britain (9) and the United States (10) also documented the cost-effectiveness and psychosocial benefits of an outpatient program. A recent review of the Colorado IDDM Registry over a 10-year period revealed that as of 1988, more than 30% of children with IDDM in Colorado received outpatient care at diagnosis (11). Furthermore, approximately 60% of the new-onset cases treated at specialized pediatric centers were handled as outpatients (11).

Our review confirms the feasibility and effectiveness of an outpatient-focused approach for pediatric diabetes. Since our program began in mid-1988, total diabetes-related hospitalizations and length of stay have decreased markedly, leading to significant declines in patient costs. In an outpatient-focused program, the only costs the patient incurs are for physician-directed services, including nurse-educator and dietitian services, and short-term hospitalization as needed for medical stabilization. Adopting this approach reduced total new onset inpatient costs by more than $100,000 per year. A similar reduction in costs due to rehospitalizations has also been achieved.

No adverse patient-care effects have been noted. Moreover, patients treated initially in an outpatient program appear to have a lower subsequent need for diabetes-related hospitalization.

Necessary components of an outpatient program for pediatric patients with diabetes include the availability of team members for the initial treatment sessions, comprehensive treatment, availability of day-to-day management advice, and a regular schedule of visits to the outpatient clinic. Our experience indicates that this outpatient approach encourages self-reliance, with confidence that professional advice and assistance are readily available.

Two potential risks exist with the outpatient approach. The first is the potential for insulin-induced hypoglycemia. To avoid this, we initiate insulin therapy using a relatively low, split-dose regimen (about 0.5 U/kg per day, two thirds in the morning, one third to one half as regular insulin, one half to two thirds as neutral protamine Hagedorn [NPH] insulin). This dose allows rapid resolution of the ketosis, and the insulin dose is adjusted gradually to stabilize blood glucose levels over subsequent days to weeks. Furthermore, the diet is planned initially at a hypercaloric level to allow for weight regain, which further decreases the risk for hypoglycemia.

The second concern is potential worsening of the ketoacidosis. Although most of our patients present with ketonuria, we do not routinely measure bicarbonate or blood pH unless the child appears clinically ill enough to need hospitalization. No specific level of serum bicarbonate or of pH has been advocated for outpatient treatment of new-onset patients, although Bonadio et al (12) found that an initial serum bicarbonate of 10 mmol/L or a pH of 7.20 predicted good outcome for outpatient management of ketoaci-

dosis in previously diagnosed children. Initiation of insulin therapy invariably inhibits ketogenesis, and the ketosis is then cleared by hydration, which we encourage. Worsening of ketoacidosis or other clinical decompensation during outpatient treatment of new-onset IDDM has not been reported in the literature and has not been observed during the author's 5 years of experience with this approach.

The major drawback that we have encountered has been the unwillingness of many third-party providers of reimbursement to accept the outpatient treatment approach, a problem that has been noted in the previous literature (5,9,10). As more information is collected regarding the short- and long-term effectiveness of outpatient programs for diabetes, we hope that these providers will make the necessary adjustments to encourage more cost-effective delivery of health care.

Acknowledgments

The author acknowledges the assistance of K. Hwu, MD, and L. Sherman, MD, diabetes nurse-educators M. O'Day and C. Clow, and M. Kana and the Medical Records Department of Texas Children's Hospital. Further acknowledgments go to G. Klingensmith, MD, and the staff of the Diabetes Clinic at The Children's Hospital, Denver, for an introduction to the outpatient-focused program approach and to J. Kirkland, MD, and F. Volpe, MD, for their support and encouragement.

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"Educating" the person with diabetes in an ambulatory setting

LUTHER B. TRAVIS, MD, FAAP, CDE

MORE THAN 30 YEARS have passed since two clinicians, in separate publications, succinctly described the deficiencies in knowledge of diabetes among patients, both adults and children, with the disease (1,2). Then, 25 years ago in 1967, Etzwiler published his paper entitled "Who's teaching the diabetic?" and identified many of the inherent problems in achieving effective education for patients with diabetes (3). This article, as much as any other, stimulated the attention of the diabetes community and helped promote the development of specific educational programs for persons with diabetes. At that time, however, the attention of the diabetes professional toward "education" was focused almost exclusively on the type of concrete information and skills that the patient should have to "survive" in a nondiabetic environment. The manner of education was devoted largely to transmitting knowledge and acquiring specific skills necessary to "care" for the diabetic condition. Since then, educational programs for persons with diabetes have undergone a process of maturation and have evolved into a sustained and protracted system whereby *the person* (with diabetes) is recognized as being of greater importance than the disease. In this plan, serious attempts are made to include the patient in decision making and to, as much as possible, incorporate the illness into the lifestyles of patients and their families.

As noted by many and described well by Schreiner (4), education is much more than the mere imparting of information to those afflicted. Diabetes, virtually singular among the various chronic illnesses of childhood, places multiple, *daily* demands on patients and their families, if they are to achieve and maintain health. More than mere knowledge, understanding of the complex array of both internal and external factors that participate in the regulation of carbohydrate metabolism is essential for patients/families to make accurate decisions concerning their health. As stated by Schreiner, "The overall reasons to conduct an educational program are to provide children and their families with the resources to live in the healthiest state possible and to assist them in adapting to their illness in a positive manner." Under the best of all circumstances, the patient becomes a partner in the care of his or her own illness.

Until quite recently in this country, almost all patients with insulin-dependent diabetes mellitus (IDDM) were admitted to a hospital inpatient unit at the onset of the disease. Even into the 1970s, most young persons with diabetes were first identified after they experienced the "ketoacidotic" state. Thus, the early phase of their treatment was in a hospital bed, and education about the condition was initiated inherently in this setting. Even then, most diabetes educators recognized that the stresses associated both with a new diagnosis and with the accompanying hospitalization diminished the effectiveness of the educational program. Therefore, most educators preferred to teach only those aspects thought to represent "survival needs" at that time, reserving the broader educational aspects of what has been termed "living with diabetes" until later, in a less intrusive, outpatient setting.

Two major factors have transpired to move most, if not all, of the educational activities into an outpatient setting. The first factor appears

Dr Travis, William W. Glauser Professor of Pediatric Nephrology, director, Divisions of Nephrology & Diabetes, Department of Pediatrics, The University of Texas Medical Branch, Galveston, TX 77555.

to have been an improved public awareness of the early symptoms of diabetes that led to medical attention being sought earlier. This, coupled with a heightened sensitivity to the early diagnosis by the medical profession and a better understanding of the seriousness of the disease, has led to increasingly earlier recognition. Today, only a minority of patients with IDDM present in severe ketoacidosis, and many children display only modest hyperglycemia, minimal ketonuria, and little evidence of weight loss and/or dehydration.

The second factor has been the attention drawn to the ever-growing costs of providing health and illness care and the efforts of various groups (ie, health professionals, the government, and the insurance industry) to curtail these costs. Because inpatient care is, by far, the most costly service provided by physicians, it was only natural for the preponderance of the educational program to move to a less expensive setting — the ambulatory area. The associated development and maturation of multidisciplinary teams, charged with the simultaneous tasks of care and education of the person with diabetes, have aided the transition.

In this issue of *Texas Medicine*, Lee describes the recent transition from a program for children with diabetes where inpatient education was a matter of policy to a program where outpatient care/education is the preferred method. Over a period of only slightly more than 2 years, this service has increased the percentage of its patients receiving only ambulatory care/education from 0 to 38%. Almost all large diabetes programs in this country, including those dealing predominantly with children, have had similar experiences, and the reader is encouraged to study Lee's reference list. One recent article (5) reports on data from the Colorado IDDM Registry showing that 23% of all children with IDDM diagnosed between 1978 and 1988 received only outpatient care/education. These authors note also that, between 1980 and 1986, of the patients treated at the Barbara Davis Center, 60% received all their care as outpatients. Our own experience at the Children's Diabetes Management Center (CDMC) at The University of Texas Medical Branch at Galveston fits in between that of Lee and that of the Barbara Davis Center.

The real benefit of ambulatory care/education for the person with diabetes is to the child and the family. The deleterious emotional effects of hospitalization on the child are well known. Hospitalization only magnifies the extreme disruption of the family produced by the illness. When people and families are in a familiar and nonthreatening environment, they cope more effectively with even extreme stressors. The English experience alluded to by Lee would even support the delivery of such care, were it possible, in the home.

The article by Lee reports an estimated "savings" of more than $100,000 per year on health-care costs. Almost every article that describes outpatient programs for diabetes management/education mentions the issue of cost savings. There is no doubt that this is factual. But, we might inquire further about this: to whom do these cost savings accrue? Are the savings funneled back into the health system in such a way that care is actually improved? In the case of those fortunate enough to have health insurance at the time of diagnosis, the insurance carrier saves money in dollars not expended for inpatient services. For those covered under governmental programs such as Medicaid or Chronically Ill and Disabled Children's (CIDC) Services, the state budget is spared the expense. Theoretically, this should eventually save money for the insured through lower premiums or for the taxpayer through reductions in the rate of taxation. But how often can anyone remember either when health insurance premiums declined or when our taxes were lessened? In fact, the savings are rarely shared with the public. Perhaps the only real personal recipient is the family without third-party coverage that is not eligible for governmental benefits.

Related to but perhaps even more basic than the questions posed so far is this question: *Who pays for the ambulatory education programs that we all believe are the single most important aspect of care directed at modifying the natural history of type I diabetes?* Lee estimates that the education sessions in his particular ambulatory setting ". . . usually last(ing) 8 to 12 hours over 2 to 3 days." Based on our extensive experience with education programs in the CDMC, a much more likely time commitment exceeds his estimate considerably. We spend 14 to 20 hours: 2 to 4 hours by the physician, 10 to 12 hours by the nurse-educator, and 2 to 4 hours by the dietician.

Even if we use a very conservative estimate of 12 hours (the maximum mentioned by Lee but lower than that of our experience) as the amount of time necessary to carry out the initiation of appropriate medical care and "basic" education, the cost can be computed from the sum of the salaries and fringe benefits of the professionals, any "clinic fee" assessed, any laboratory

studies performed, and the cost of whatever supplies and/or educational materials are given to the patient. In almost any center in Texas, the costs for these services will range from $500 to $800. Even the best insurance programs will compensate for significantly less than one half of these quite nominal costs. The reason? Private insurers have not responded to pleas from either the individually insured or from such bodies as the American Diabetes Association, the National Diabetes Advisory Board or, in this state, from similar appeals by the Texas Diabetes Council. *"Diabetes Education" is not a compensatable charge under most insurance carriers.* If charged, it will be disallowed! Reimbursements for ambulatory services have traditionally been significantly less than those for comparable services delivered to inpatients. In Texas, a nurse cannot generate a separate charge for "educational services." And even with the convincing evidence on hand that appropriate education of the person/family with IDDM leads to significant decreases in later expenditures for the care of complications, the issue falls on deaf ears. Who pays for diabetes education? The health center in which the diabetes program resides pays for it! In this age where all health providers and institutions are under a mandate to "contain" their costs, we must wonder for how long the health centers will continue to absorb such expenses.

One other important issue arising from Dr Lee's article begs addressing. Can practitioners, be they generalists, internists, or pediatricians, carry out an ambulatory care and education program for the newly diagnosed person with diabetes? Or should (must) they always refer such patients to a medical center where a program exists. From a standpoint of medical care, the answer will be determined by whether or not the physician feels competent or "safe" in managing new-onset diabetes on an outpatient basis. Many will not immediately feel comfortable in carrying out this task. And where does the practitioner acquire the services of a nurse who can help in the instruction on techniques of performing fingerstick blood glucose determinations or insulin administration? Traditionally, these services have come from the inpatient nurse. Who will train the office nurse and at what expense? Who will certify that this nurse is a competent teacher? From where does the "team" come? Unfortunately, the practitioners may discover that an inpatient hospitalization means "less money lost" from their incomes. Ambulatory care and education save money — but for whom?

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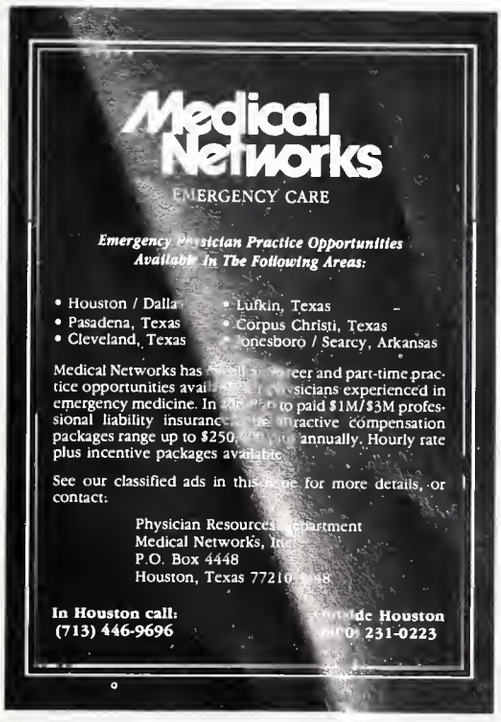

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Dallas Area: Staff positions available for Emergency Physicians who are BC/BE in a primary care specialty or have equivalent emergency medicine experience. This Level II facility has an annual volume of approximately 14,000 and compensation begins at $100,000/year. For more information on this or other opportunities in Texas, contact Sterling Healthcare, Inc., at 1-800-999-3728, or send CV to 8700 Crownhill, Suite 600, San Antonio, TX 78209.

Outstanding Emergency Medicine Opportunities — Sterling Healthcare, Inc., a progressive physician-oriented group committed to the highest standards in emergency medicine, has outstanding opportunities for qualified physicians. Compensation packages include a minimum hourly guarantee plus a percentage of collections, with paid $1M/$3M professional liability insurance included. Physicians also benefit by working in a flexible environment as independent contractors. To obtain more information, contact Sterling Healthcare, Inc., 8700 Crownhill, Suite 600, San Antonio, TX 78209 or call 1-800-999-3728.

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Orthopedic Surgeon BC/BE — Opportunity for a General ORS to join an established, respected practice in a beautiful, mid-sized Texas coastal city; a great place to raise a family. Office and practice in a state-of-the-art facility now under construction. Excellent financial arrangements and benefits. Ownership with NO investment within short period of time. Contact Healthcare Dynamics, 4615 N Braeswood, # 207D, Houston, TX 77096 or call 1-800-944-4047.

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Pediatric Intensivist — Dallas. A three-man group of Pediatric Intensivists now seeking fourth member. This group is part of the Center for Children at our 555-bed hospital in North Dallas where we offer a 12-bed Pediatric ICU. This Center features other pediatric subspecialists in a new office on the hospital campus. Send CV to Gordon Crawford, Professional Recruitment, Humana Inc., Dept TX7-2L, PO Box 1438, Louisville, KY 40201-1438, or call toll free 1-800-626-1590, ext 267.

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Ambulatory Surgery Center in Dallas, Texas, seeking BC/BE internist or family practitioner to perform pre-op physical and to monitor pre-op patients. No weekends, call, or evenings required. Salary 80K plus benefits. Benefit package includes medical, dental, and malpractice insurance. Please send CV and photo to Dr Whitman, 12308 Shiremont Dr, Dallas, TX 75230.

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ORTHEAST TEXAS
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amily physician needed to deliver basic primary care "fast track" unit of busy ER. The regular hours of is position will allow you to enjoy a nice lifestyle in a ty with tremendous amenities. Salaried position. all us for details. Contact: Vicki Truitt

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FORT WORTH
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NORTHEAST TEXAS
Regional medical center serving 200,000 seeks BE/BC neurologist for practice; fee for service; shared call. Modern medical facilities. 100+ doctors in town. Progressive, family-oriented community with strong, diversified economy, excellent schools. Many social and recreational opportunities. Generous incentive package to qualified physician.
Contact: Barry Strittmatter.

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NORTHEAST TEXAS
Regional medical center serving 200,000 seeks BE/BC OB/GYN for private practice (to share call with three other OB/GYNs). New L&D unit, women's center. Strong neonatal support. Progressive family-oriented community with strong, diversified economy; excellent schools. Many social and recreational opportunities. Comprehensive incentive package to qualified physician. Contact: Vicki Truitt.

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BE/BC OB/GYN needed for associate practice in north central Texas community of approximately 21,000 (serving referral area of 206,000). Regional medical center with ultra-modern OB facilities and equipment. Area renown for recreational facilities. One hour from Dallas/Fort Worth metropolitan area. Contact: Vicki Truitt.

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Oncology group seeks BE/BC medical oncologist for associate practice in NE Texas community with referral area of 200,000. Modern medical facilities in town with more than 100 physicians. New cancer center almost complete. Progressive family-oriented community with strong, diversified economy; excellent schools. Many social and recreational opportunities. Generous compensation and benefits to high caliber physician. Contact: Jim Truitt.

FORT WORTH
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Regional medical center in community of approximately 21,000 (serving referral area of 206,000) seeks BC otolaryngologist. Associate or solo practice possibilities. Ultra-modern hospital facilities. Area renown for recreational facilities; easy access to D/FW Metroplex. Competitive incentive package to qualified physician. Contact: Vicki Truitt.

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Recently trained, BC female pediatrician seeks compatible associate for private practice. Four-way shared call; superb hospital facilities; Level II nursery. Competitive income and benefits. Attractive area with easy access to Dallas/Fort Worth.
Contact: Vicki Truitt.

SOUTH TEXAS
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NORTHEAST TEXAS
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FORT WORTH
Immediate need for fellowship trained pulmonary medicine specialist to accommodate full time, 100% pulmonary and critical care consultative service. Teaching hospital, resident supervision. Limited weekend and evening call responsibility, but coverage available from BC pulmonologist. Great opportunity for interesting practice with excellent life style. Good income and benefits.
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CME / Continuing Education Directory

Courses

AUGUST

Allergy

Aug 6–8, 1992
Clinical Allergy for the Practicing Physician. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Cardiology

Aug 13–15, 1992
Critical Care Cardiology. San Francisco. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Aug 24–26, 1992
Challenges in Clinical Cardiology. Grand Teton National Park, Wyo. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Computer Applications

Aug 1, 1992
Getting Organized: Personal File Management. Austin. Contact Texas Medical Association Library, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1547

Family Medicine

Aug 6–9, 1992
Family Medicine Update. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Aug 13–15, 1992
Family Medicine in the Rockies. Copper Mountain, Colo. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Internal Medicine

Aug 3–7, 1992
Annual Internal Medicine Review. South Padre Island. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 765[illegible] (817) 774-4083

Obstetrics and Gynecology

Aug 21–22, 1992
Endoscopic Stapling Techniques for the Practicing Gynecologist. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Oncology

Aug 1, 1992
Supportive Care Mini-Symposium. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Ophthalmology

Aug 7–8, 1992
Phacoemulsification Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Pathology

Aug 9–15, 1992
Fine Needle Biopsy Course. Mauna Lani, Hawaii. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Risk Management

Aug 15, 1992
Grand Rounds in Medical Malpractice. South Padre Island. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Aug 27, 1992
From Deposition to Courtroom Workshop. Houston. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411

SEPTEMBER

Cardiology

Sep 14–17, 1992
Clinical Electrophysiology: Cardiovascular Board Review. Philadelphia. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Sep 17–19, 1992
Colloquium on Cardiovascular Therapy. Santa Fe, NM. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Sep 21–23, 1992
Clinical Application of Echocardiographic Techniques. Indianapolis. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Dermatology

Sep 11–12, 1992
Wound Care: A Team Approach. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Internal Medicine

Sep 8–13, 1992
Intensive Review of Internal Medicine. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Obstetrics and Gynecology

Sep 12–13, 1992
Transvaginal Sonography. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Ophthalmology

Sep 10–12, 1992
Welsh Cataract Congress. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Sep 10–13, 1992
Uveitis & Retinal Frontiers. Carmel, Calif. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

Sep 18–19, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Psychiatry

Sep 24–27, 1992
Multiplicity of Approaches to Treatment of Multiple Personality Disorder. Austin. Contact Don Young, Shoal Creek Hospital, 3501 Mills Ave, Austin, TX 78731 (512) 452-0361

ep 26–Oct 28, 1992
Psychoanalytic Concepts of Character: Theory & Practice. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Risk Management

ep 19, 1992
From Deposition to Courtroom. Austin. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411

ep 19–20, 1992
Grand Rounds in Medical Malpractice. El Paso. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042, (713) 789-6518

ept 24, 1992
Grand Rounds in Medical Malpractice. Lubbock. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042, (713) 789-6518

OCTOBER

Dermatology

Oct 17–18, 1992
The Skin from A to Z. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Oct 14–16, 1992
Experience in MDA-ALS Clinic. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Obstetrics and Gynecology

Oct 31–Nov 1, 1992
Transvaginal Sonography. Houston. Contact Department of Education, American Academy of Pediatrics, PO Box 927, Elk Grove Village, IL 60009-0927 (800) 433-9016

Oncology

Oct 10–13, 1992
Pharmacy Symposium on Cancer Chemotherapy. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Oct 17–23, 1992
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Risk Management

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Oct 1, 1992 — San Antonio
Oct 3–4, 1992 — San Antonio
Oct 8, 1992 — Dallas
Oct 10, 1992 — New Orleans
Oct 24–25, 1992 — Houston

Oct 22, 1992
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NOVEMBER

Computer Applications

Nov 7, 1992
GRATEFUL MED: Computer Access to Information. Austin. Contact Texas Medical Association Library, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1547

General Medicine

Nov 21, 1992
Hyperlipidemia Seminar. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Neurology

Nov 13–15, 1992
Update & Review in Neurology. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Oncology

Nov 6–10, 1992
International Symposium on Polyamines in Cancer. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Otolaryngology

Nov 5–7, 1992
Otolaryngology Update. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA, 94143-0742 (415) 476-4251

Pediatrics

Nov 5, 1992
Pediatric Advanced Life Support Renewal Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Nov 6–7, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Psychiatry

Nov 13–15, 1992
Group Therapy Symposium. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

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Nov 19, 1992
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Nov 21–22, 1992
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Aug–Nov, 1992

From Deposition to Courtroom
Aug 27, Houston
Sept 19, Austin (during TMA Fall Leadership Conference)
Oct 22, Dallas
Nov 19, San Antonio

Calendar of Meetings

•Denotes Texas meeting

September

Sept 11–13, 1992, El Paso
•*Texas Society of Anesthesiologists Annual Meeting*
Contact TSA, 401 W 15th St, Ste 990, Austin, TX 78701 (512) 370-1659

Sept 19, 1992, Austin
•Texas Medical Association Fall Leadership Conference
Contact Jon Hornaday, 401 W 15th St, Austin 78701 (800) 880-1300 or (512) 370-1345

Sept 27–30, 1992, Houston
•*Texas Technology Transfer Association*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Sept 29–Oct 4, 1992, Quebec
American Society of Cytology Annual Scientific Meeting
Contact Yener S. Erozan, MD, 1015 Chestnut St, Ste 1518, Philadelphia, PA 19107 (215) 922-3839

October

Oct 22–25, 1992, San Diego
American Pain Society Annual Meeting
Contact APS, 5700 Old Orchard Rd, 1st Floor, Skokie, IL 60077-1057 (708) 966-5595

Oct 31–Nov 4, 1992, Dallas
•*Pan American Medical Association Quincentenary Congress*
Contact PAMA, 3600 Gaston Ave, Ste 1051, Dallas, TX 75246 (214) 824-2087

November

Nov 1–2, 1992, Phoenix
Leukemia Society of America Symposium
Contact LSA, 733 Third Ave, New York, NY 10017 (212) 573-8484, ext 138

Nov 18–21, 1992, Houston
•*American Association for Cancer Education*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

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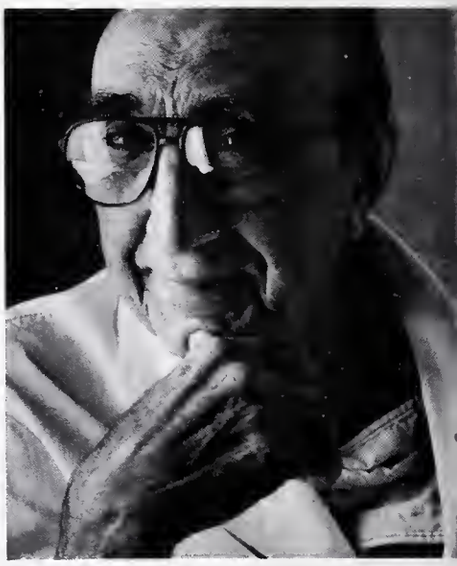

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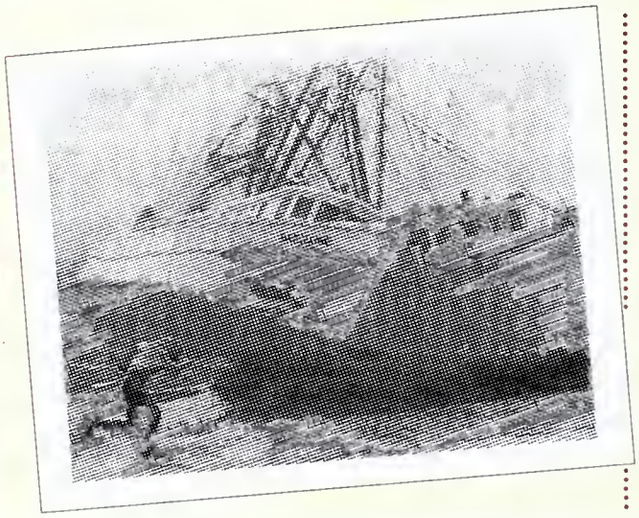
AUGUST 1992 • VOLUME 88 NO. 8

Texas **M**edicine **F**eature



9/26/67— BROWNSVILLE, TEX: A sightseer braves heavy rains and wind from Hurricane Beulah for a close-up view of two boats aground near Port Isabel. UPI/BETTMANN

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When catastrophe strikes: Physicians' roles in emergency medicine

State emergency planning officials say it's not a matter of if disaster will strike, but when. Doctors are key players in response plans.

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UT anatomist critiques the Houston exhibition

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Ensuring Quality--Managing Change

- ✓ Explore why physician leadership is essential to maintain quality patient care in these challenging, changing times from AMA President John L. Clowe, MD.
- ✓ Look at pending health-care legislation on Capitol Hill with U.S. Rep. J.J. "Jake" Pickle.
- ✓ Hear about the state of the state from invited guest Lt. Gov. Bob Bullock.
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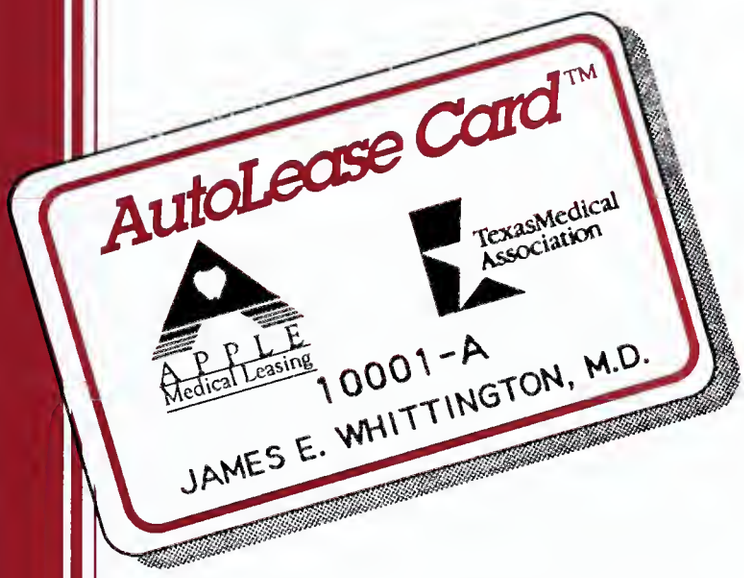

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Letters

Universal access: the other side of the argument

THE INTERESTING ARTICLE BY George L. Bohmfalk, MD, (*Texas Medicine*, May 1992, pp 16–17), in which he argues for universal access to health care, deserves some comments:

— Dr Bohmfalk writes, "Nothing mandates that government has to run a program of national health care," but later in the paragraph he states, "The organizations, hybrids of insurance companies and HMOs, would compete for enrollees, whose uniform premiums would be paid directly by the federal government." How would the federal government pay premiums for a program it doesn't run? And, since "he who pays the piper calls the tune," if the federal government pays the premiums, they certainly will call the tune, which they are currently doing and not well at all.

— To Dr Bohmfalk, the proposal to "dock Medicaid patients $25 for ER-abusing sadly exposes the extent to which the enemy is us." Even in England, where socialized medicine was born, patients bear a certain amount of the cost for emergency room visits and prescriptions. Surely Dr Bohmfalk is aware that some Medicaid patients visit in 24 to 48 hours emergency rooms within 10 to 15 miles of each other, receiving prescriptions from each. Recent investigations by the media have documented a black market in which some Medicaid patients sell their medications. If patients paid even a nominal amount for visits and prescriptions, this might diminish that problem. Additionally, it might discourage Medicaid patients who call ambulances to bring them to emergency departments for medical conditions that have existed from 7 to 10 days in many cases.

— I do not see why we should be apologetic because a few physicians make a million dollars annually, while we gladly accept chief executive officers, professional sports players, and entertainment stars or semi-stars with multimillion dollar annual contracts.

— Physicians have never backed off from seeing emergency patients, whether they are paying or nonpaying. But when it comes to elective cases, I think more regulation of the emergency department would prevent them from being used as come-as-you-please clinics.

Adel G. Nafrawi, MD
1311 Hickory
Abilene, TX 79601

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IN RESPONSE

I APPRECIATE DR NAFRAWI'S comments. The questions he raises occur to everyone who ponders these dilemmas.

The federal government pays for many things that it doesn't actually run. It gives welfare money with only broad restrictions as to how it may be spent. It contracts with defense companies that supply products but run their own businesses.

In this case, the government would pay for, regulate, and oversee a program of national health care administered by private companies. Government *will* "call the tune" in that it will demand certain quality standards of medical performance. The administering organizations will have to deliver those standards and make a profit. I anticipate more physician anxiety from having finally to become cost-conscious, at the risk of being removed from HMO, PPO, and other physician panels. Economic credentialing has to be a part of the picture, although never the only factor in determining what makes a good physician.

I previously believed in nominal co-pays, thinking that they *must* reduce demand for services. However, there is ample evidence to the contrary, and the cost of collecting such small payments is greater than what is collected. And, again, I suspect that those Medicaid patients who summon ambulances for non-acute conditions do so because they believe they are in more dire straits than they actually are and because they have no other means of transportation. Ask one sometime.

As to having a problem with sumptuous physician incomes, but not with those of rock, movie, sports, and business stars, remember why we all said we went into this business: to help people. No one is ever forced to spend his money on music, ball games, or Disneyland. Most of our patients have no choice when they spend money on us. Patients accept our making comfortable incomes caring for them; they get upset when they perceive we're

ripping them off.

And, sad to recall, we physicians have a rather unadmirable record when it comes to seeing nonpaying emergency patients. That's why that bad ole government found it necessary to make a law forbidding us to decline on economic grounds patient transfers from other hospitals. And most hospitals now have contract emergency room physicians who see most of the unfunded patients, such that private physicians conveniently don't have to. As to more regulation, heaven forbid! What we need is more insurance coverage, like universal.

George L. Bohmfalk, MD
1001 Main St
Texarkana, TX 75501

Let's watch the language when talking about managed care

I APPLAUD THE TMA'S RECENT efforts to bring managed care organizations and Texas physicians together for dialogue. (See "Council on Health Facilities conducts managed care review," *Texas Medicine*, February 1992, p 54, and "Consultants advise physicians to get involved in managed care," *Texas Medicine*, May 1992, pp 28–29.)

In the May article, John Deane is quoted: "Physicians must belly up to the table and take a leadership role in deciding just how health care is to be managed." This is precisely the reason that I became a full-time medical manager, and it is the reason that physicians and managed care organizations must work together.

Unfortunately, this same article starts off with the destructive statement, "Like death and taxes, managed care is an inevitable part of the future, according to health-care consultants." And the February article states, "Increasingly, both the government and private insurers have become involved in the medical decision-making process in ways that are, at best, an unwelcome intrusion into the autonomy of a physician, and at worst, a barrier to quality health care for millions of Texans and other Americans."

Managed care represents a superb opportunity for us all to learn and to *improve* quality. By working cooperatively we can develop health care that is of higher quality and greater efficiency and efficacy and that is more outcome-driven than income-driven.

Only in very recent times has the profession begun to look seriously at outcomes. We are beginning to question the efficacy of many traditional preventive and treatment regimens. The US Preventive Services Task Force, in its 1989 report, "Guide to Clinical Preventive Services — An Assessment of the Effectiveness of 169 Interventions," has painted a strikingly sparse picture of which interventions are truly useful.

This is the stuff of managed care — scrutinizing what we do, when we do it, where we do it, and how we do it, and then managing the whole process in a way that maximizes efficacy and minimizes waste. The result is a brand of medicine that is of higher quality and lower cost.

TMA's excellent Managed Care Review Program, designed to enhance cooperation between practicing physicians and health-care managers, is partially sabotaged by the statement from Karen Batory, TMA director of health-care delivery, in the February *Texas Medicine* article: "I think we are providing physicians with some extra weapons to deal with the problems, so they don't simply give up because the hassles have beaten them." Further, the program's information-collecting form is prominently and confrontationally labeled, "BEING HASSLED? TMA Hassle Factor Log."

I assume that the TMA, even though it is a "physician advocate," wants to see successful solutions to managed care issues in which both parties are winners. If we are to foster successful communication, we need to be attentive to our language, just as a physician must watch both verbal and body language in the examining room. Let's bury words like "control and interference" and replace them with words like "involvement and interaction." After all, the physicians, the payers, and the patients are all pedaling the same bicycle-built-for-three.

David P. Olson, MD
Medical Director
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Upfront

A chance to recharge: TMA conference set for Sept 19

WHAT EFFECT DO THE perpetual changes faced by the medical profession have on your ability to provide quality care? Texas Medical Association's Fall Leadership Conference offers a chance to hear what your colleagues and other experts think about that and additional current issues.

Scheduled for Saturday, September 19, at the Stouffer Austin Hotel, the conference is open free to all TMA members and association guests. Registration for nonmember physicians is $100.

Featured speakers include John L. Clowe, MD, Schenectady, NY, president of the American Medical Association; US Rep J.J. "Jake" Pickle (D-Texas), member of the House Ways and Means Committee; M. Roy Schwarz, MD, Chicago, AMA senior vice president of medical education and science; and state Sen Chet Brooks, (D-Pasadena), chairman of the Senate Health and Human Services Committee. Senator Brooks will head a panel session on legislative health issues.

The featured speakers and panel are scheduled during the conference's general session, 9:30 am to 12:30 pm. Following a luncheon hosted by Texas Medical Liability Trust, participants may attend a risk management session from 2 to 5 pm. The session, "From Deposition to Courtroom," with Houston attorney James B. Edwards, JD, costs $75 for TMA members and $125 for nonmembers. The workshop may be supplemented with a 12-hour independent study program designed to qualify physicians for a discount from liability insurance carriers under House Bill 18. The cost of the complete 15-hour program is $185 for TMA members and $285 for nonmembers.

In a free "Dawn Duster" session at 7:45 am, Dallas-based medical payment consultant Harold Whittington will present ways to reduce hassles brought on by Medicare's resource-based relative value scale.

Fall LEADERSHIP CONFERENCE SEPTEMBER 19 1992 AUSTIN

Most of the association's boards, councils, and committees also will meet during the conference weekend.

Although not required for the general session and dawn duster, conference preregistration is suggested. For further information, contact Jon R. Hornaday, director, TMA Special Services, (800) 880-1300 or (512) 370-1346. To register for the risk management program, contact Kathleen Threadgill, TMA office of risk management, (800) 880-1300 or (512) 370-1411.

Issue papers available to physicians

HEALTH-CARE REFORM, public health trends, and border health problems are among serious medical concerns addressed in a series of issue papers developed by the Texas Medical Association's public relations department and available to member physicians.

The papers are a good source of in-depth background information on topics that physicians frequently are asked to address in speaking engagements or in interviews with the news media.

The issue papers were written as part of TMA's Media Guide to Medicine in Texas, a comprehensive resource containing information on

TEXAS MEDICINE WINS NATIONAL AWARD FOR EXCELLENCE

TEXAS MEDICINE RECENTLY received second place in the category of general excellence for magazines in a national competition of association publications.

The award, part of the annual Excel Awards competition, was presented by the Society of National Association Publications at its publications management conference in Washington, DC, in June.

Judging in the category of general excellence was on the basis of best writing, content, graphic design, and overall packaging.

"We are particularly pleased by the publication's strong showing in a field primarily composed of publications produced by national associations," said Glen Journeay, MD, Austin, chairman of the Editorial Committee for *Texas Medicine*.

In its award entry, TMA stated that "*Texas Medicine* concentrates on news about and for the medical profession, crossing all medical specialty lines and giving Texas physicians a comprehensive look at issues affecting medical care. It includes news of the medical federation, public health, legislation, medical economics, legal topics, science, and medical education. The magazine's eye-catching graphic design helps the publication stand out on a physician's crowded desk."

TMA and medicine in general. It is designed to help medical writers do a better job in reporting on health and medical issues. Each paper examines current activities or trends in a particular area and outlines TMA efforts to address the issue.

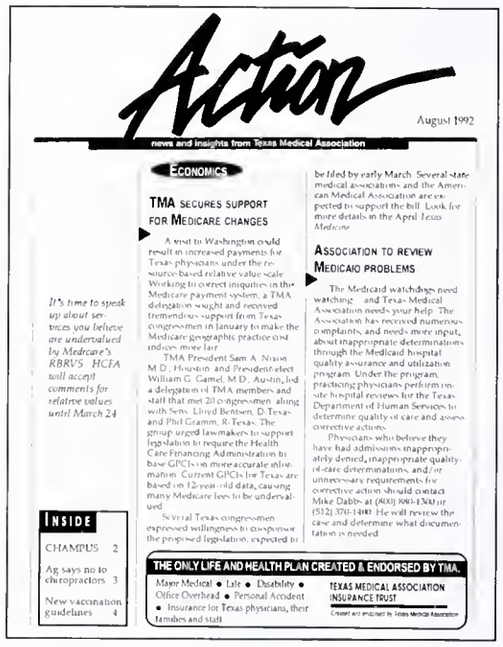
Papers on the three issues listed above already have been printed. Additional issue papers will be developed throughout the year.

While the issue papers are intended primarily for the media, single copies are available to TMA members. Physicians interested in obtaining copies should contact the TMA public relations department, 401 W 15th St, Austin, TX 78701, (800) 880-1300 or (512) 370-1392.

News video and redesigned newsletter target busy physicians

A FRESH, INNOVATIVE LOOK for Texas Medical Association's popular newsletter, *Action*, and a pilot news video that is part of a new communication program are two of the association's latest means of facilitating communication with members.

The August issue of *Action* features a new design and format to provide an easy-to-read overview of issues.



Action

August 1992

news and insights from Texas Medical Association

ECONOMICS

TMA SECURES SUPPORT FOR MEDICARE CHANGES

A visit to Washington could result in increased payments for Texas physicians under the resource-based relative value scale. Working to correct inquiries in the Medicare payment system, a TMA delegation sought and received tremendous support from Texas congressmen in January to make the Medicare geographic practice cost indices more fair.

TMA President Sam A. Nixon, M.D., Houston, and President-elect William G. Gamel, M.D., Austin, led a delegation of TMA members and staff that met 20 congressmen, along with Sens. Lloyd Bentsen, D-Texas, and Phil Gramm, R-Texas. The group urged lawmakers to support legislation to require the Health Care Financing Administration to base GPCIs on more accurate information. Current GPCIs for Texas are based on 12-year-old data, causing many Medicare fees to be undervalued.

Several Texas congressmen expressed willingness to cosponsor the proposed legislation, expected to be filed by early March. Several state medical associations and the American Medical Association are expected to support the bill. Look for more details in the April Texas Medicine.

It's time to speak up about services you believe are undervalued by Medicare's RBRVS. HCFA will accept comments for relative values until March 24.

ASSOCIATION TO REVIEW MEDICAID PROBLEMS

The Medicaid watchdogs need watching — and Texas Medical Association needs your help. The Association has received numerous complaints, and needs more input, about inappropriate determinations through the Medicaid hospital quality assurance and utilization program. Under the program, practicing physicians perform on-site hospital reviews for the Texas Department of Human Services to determine quality of care and assess corrective actions.

Physicians who believe they have had admissions inappropriately denied, inappropriate quality-of-care determinations, and/or unnecessary requirements for corrective action should contact Mike Dabbs at (800) 880-1300 or (512) 370-1400. He will review the case and determine what documentation is needed.

INSIDE

CHAMPUS 2

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THE ONLY LIFE AND HEALTH PLAN CREATED & ENDORSED BY TMA.

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TEXAS MEDICAL ASSOCIATION INSURANCE TRUST

Created and endorsed by Texas Medical Association

Stories emphasize news about legislative, legal, public health, and medical economics, with particular emphasis on TMA's advocacy role in issues.

The new design can accommodate more graphics to draw attention to priority issues. A front-page index and subject headings help physicians find stories of interest. A new "briefs" column lists short news updates.

The 10-minute news video, produced by the TMA public relations department in July, is one part of the Texas Physicians Speak Out program, a communication strategy project proposed by the TMA Council on Communication and adopted in 1991. Hosted by Sue Rudd Wynn, MD, Fort Worth, chair of the communication council, the video is designed to keep TMA members up-to-date on the association's initiatives. Copies of the video were sent to county medical societies and hospital medical staffs for possible use at their next regular meeting.

Mark your calendar for 1993 Annual Session

Texas Medical Association's 126th Annual Session

May 13–16, 1993

GEORGE R. BROWN CONVENTION CENTER, HOUSTON

UT anatomist critiques Leonardo's drawings in Houston exhibition

Nora K. Shire
Writer, Office of Community Affairs, The University of Texas Medical School at Houston

"THESE DRAWINGS ARE alive, the skin is transparent, the pulse can be felt. There is no drawing here that would not be welcomed in a modern-day anatomy text.

"Never before equalled and never surpassed, this is at once art, science, anatomy, kinesiology, physics and architecture — demonstrating all of Leonardo da Vinci's talents utilized together."

That is how Ron Philo, PhD, describes many of Leonardo's anatomical drawings that he recently examined in the Royal Library at Windsor Castle in England. "I

Ron Philo, PhD, anatomist at The University of Texas Medical School at Houston, prepared comments for the catalog of the exhibition of Leonardo da Vinci's anatomical drawings.

"The Muscles of the Arm, Shoulder and Neck," circa 1510–1511, by Leonardo da Vinci, is a pen and ink with wash over traces of black chalk and stylus underdrawing with small red chalk strokes. (Photo, courtesy Windsor Castle, Royal Library. Copyright HM Queen Elizabeth II.)

"The Skull Sectioned," 1489, by Leonardo da Vinci, is the earliest dated work in the exhibition at The Museum of Fine Arts, Houston. (Photo, courtesy Windsor Castle, Royal Library. Copyright HM Queen Elizabeth II.)

walked into the room, and these 500-year-old drawings were just laying on the desk," he says.

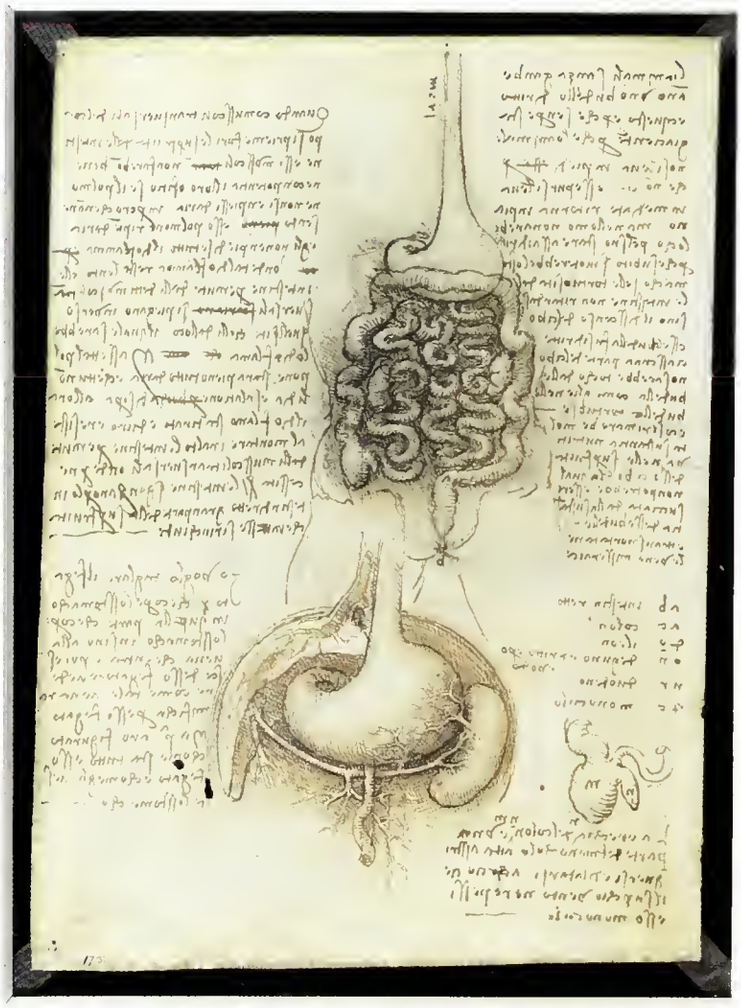
Dr Philo, a modern-day anatomist who is director of the Human Structure Facility and senior lecturer in the department of neurobiology and anatomy at The University of Texas Medical School at Houston, was charged with judging how accurate by today's standards Leonardo da Vinci's work is.

He went to Windsor at the request of Peter Marzio, PhD, director of The Museum of Fine Arts, Houston, in preparation for the exhibition *Leonardo da Vinci: The Anatomy of Man. Drawings from the Collection of Her Majesty Queen Elizabeth II*, which is on view in Houston through September 6. It also will exhibit at the Philadelphia Museum of Art, September 19 through November 29, and the Museum of Fine Arts, Boston, December 11 through February 21, 1993.

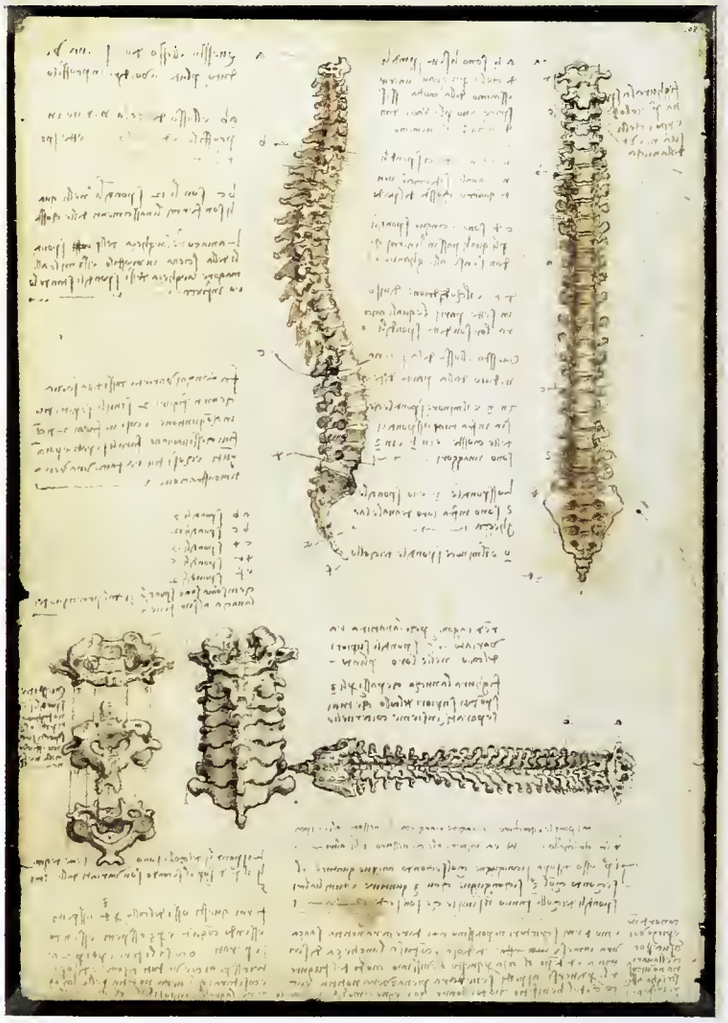
From his observations of the drawings, Dr Philo prepared comments for the exhibition's catalog written by Martin Clayton, assistant curator in the print room at Windsor.

Anatomically speaking, observes Dr Philo, the finest works of Leonardo included in this exhibition and catalog begin with the sheet, "The Spinal Column," and end some eight sheets later. These were created in 1510 and 1511 and were part of the artist's third and final phase of anatomical investigation.

The drawing of the spine corrected a centuries-old confusion as to



In "The Alimentary Tract and Subdiaphragmatic Organs," 1508, Leonardo da Vinci presented the first illustration of the appendix (bottom right). (Photo, courtesy Windsor Castle, Royal Library. Copyright HM Queen Elizabeth II.)



Leonardo da Vinci's "The Spinal Column," circa 1510–1511, is one of the finest works in the exhibition, says Ron Philo, PhD, anatomist. (Photo, courtesy Windsor Castle, Royal Library. Copyright HM Queen Elizabeth II.)

the number of vertebrae, their relative proportion, and the shape of the spine. "Leonardo understood the importance of the curvatures for weight-bearing and posture," says Dr Philo.

The subject matter of the 16 pages (eight sheets with drawings on both sides) is primarily osteological, myological, and topographical. "Skeletal material was probably easier to obtain than were cadavers, while many of the muscles were visible from the surface, especially in thin individuals," Dr Philo explains.

"Moreover, Leonardo's keen architectural mind and bioengineer's mentality could correctly interpret purpose, if not exact physiology, for the head and appendages far easier than for the viscera. Few errors exist in these sixteen pages; there are variants, however, and on some the perspective may need explanation. A vast number of structures are illustrated."

"The Muscles of the Arm, Shoulder and Neck" is the high point of the exhibition in Dr Philo's opinion. Among his other anatomical favorites are "The Deep Structure of the Shoulder," "The Superficial Anatomy of the Shoulder," "The Muscles of the Arm and the Superficial Vessels," and "The Bones and Muscles of the Leg."

"The action of the muscle was one of Leonardo's constant concerns," Dr Philo writes in the catalog. "He used these drawings of the bones of the lower limb not only for illustration of the structures, but also for theorization on the actions

While not anatomically correct, Leonardo da Vinci's "The Fetus and Linings of the Uterus," circa 1511–1513, is greatly advanced over the drawings of his predecessors and contemporaries. (Photo, courtesy Windsor Castle, Royal Library. Copyright HM Queen Elizabeth II.)

of the muscles which moved the bones and joints.

"The rope or cords on some of the drawings are to represent direction of muscle force. A translation of the notes indicates that Leonardo may have independently grasped the notion of antagonistic groups of muscles and that he was well along the way to understanding the mechanism of motion and muscle action of the knee."

The exhibition features 23 sheets, most double-sided, of 41 drawings of this Italian Renaissance artist. Each sheet has been encapsulated between two thin layers of acrylic sheeting containing an ultraviolet filter. This in turn was set into mount board, thus providing a safe environment and enabling both sides to be seen. The assemblage, which incorporates Leonardo's studies and commentaries, reflects 25 years in his life.

The installation is based on the three phases of his anatomical investigation. The first phase, from 1487 to 1495, was an expression of Leonardo's belief in the scientific nature of painting. "The Skull Sectioned," 1489, is among the drawings from this phase and is the earliest dated work in the exhibit. This drawing is accurate for use to this day, says Dr Philo.

"Here Leonardo has set straight an old argument, possibly begun by Aristotle, that asserted women have fewer teeth than men . . . Though the schematic depictions of the teeth bear inaccuracies in their roots, the dental formula of 4:2:4:6 may easily be read, from right to left."

From 1504 to 1509, Leonardo was in the second phase of investigation to aid in his important commission, *The Battle of Anghiari*, a huge mural never completed.

"The Alimentary Tract and Subdiaphragmatic Organs," 1508, illustrates this phase. "Although the most prominent features of this sheet are continued views of the contents of the abdomen, the small figure on the bottom right is the most important anatomical representation, for here is presented the first illustration of the appendix."

One is first tempted to criticize the caecum for being disproportionately large, but caeca of great size are routinely encountered in the laboratory, Dr Philo explains.

The third phase, from 1510–1513, was in conjunction with Marcantino della Torre, an anatomist at the University of Pavia. It is fortunate that della Torre was a follower of 3rd century Roman physician Galen, for during this period Leonardo's drawing of muscles and bones reached its zenith, stimulated by Galenic methods of observation and deduction.

One of the intriguing facts about Leonardo da Vinci, one of the pivotal figures in the development of Western art and the father of the High Renaissance, is that he was not a recognized anatomist of his day.

In fact, until the turn of this century, when the Windsor family permitted scholars access to the drawings and the chronology was unraveled, history did not recognize Leonardo as an anatomist. (Records show the collection has been the property of the Windsor family since 1690).

In his lifetime Leonardo did not work as an anatomist professionally, never taught the subject and, most important, never published any of his discoveries. Few of his associates even knew the extent of his medical research.

The exhibit consists of sheets from Leonardo's sketch pad, and because the artist utilized both sides of the paper, the installation of the exhibit was a challenge. In Leonardo's day, paper was not easy to come by and he recycled every piece year after year.

"So you will see on the same sheet a drawing of an internal organ, sketches of a dead person, the architectural plans for a palace garden, perhaps a schematic of the eye and then the blood flow to the heart. Drawings done years apart will be on the same sheet," Dr Philo explains.

"Leonardo was one of the most original and perceptive anatomists of his own or any other time, and yet a history of European anatomical knowledge may legitimately be written without once mentioning his name," Mr Clayton writes in the catalog, a lavishly illustrated volume of coffee-table quality.

"Seldom can a scientist have made so many advances while changing the course of his chosen subject so little."

Dr Philo observes: "One of the truly interesting aspects of Leonardo's drawings is the fine detail that is not visible in any form of photographs. Even in this day of high-quality reproduction, you must see the drawings with your own eyes to really appreciate Leonardo's talent."

Because dissection of humans was not allowed except on criminals who had been executed, anatomists in Leonardo's lifetime depended on animal dissections to study the internal structure and functions. Leonardo also studied animals, and his drawings show what an excellent comparative anatomist he was.

"Dissecting and drawing is not as easy as it sounds," comments Dr Philo. "You either dissect and stop and sketch and repeat the process many times or you dissect and draw from memory. Because of the accuracy of his work, Leonardo probably did a combination."

Many of the drawings from his medical research were done for the purpose of producing a book on the anatomy of man. Several outlines for the work survive.

Leonardo's accuracy, seen in the drawing of the skull, set the precedent for future precision. The technique of showing one half of the skull cut away to reveal structures at a different depth is still used today.

Another artistic technique adapted from Leonardo's work is seen in the drawing of "The Spinal Column," which displays the parts separately yet indicates the connections. Because this approach is so common today, viewers may fail to recognize the originality Leonardo showed in employing the device.

Not all of Leonardo's drawings are anatomically correct. In "The Fetus and Linings of the Uterus," the images presented are derived from animal dissections and the artist's personal observation of the process of pregnancy.

"Although the parts are out of position and there are errors, Leonardo's work is greatly advanced over his predecessors and contemporaries," Dr Philo emphasizes.

"Let us not fault Leonardo too much; rather we should look again at the problems facing him — the difficulty in obtaining human subject matter for dissection, no preservation for specimens and no microscope."

His primary tool was his superb powers of observation. ★

Editor's note: For additional information on the exhibition or catalog, call The Museum of Fine Arts, Houston, 713-639-7300.

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Accreditation

CME Category I: The Texas Tech University Health Sciences Center is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The Texas Tech University Health Sciences Center designates this continuing medical education activity for 5.5 credit hours in Category I of the Physician's Recognition Award of the American Medical Association.

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People

NEWSMAKERS

Dallas psychiatrist **Gonzalo A. Aillon, MD,** was recognized by the National Awards Program of the American College of Physician Executives for establishing the Day Treatment Center of Dallas as an alternative to inpatient psychiatric hospitalization.

Recognizing outstanding service to the medical profession and to mankind, The University of Texas Medical Branch at Galveston presented the Ashbel Smith Distinguished Alumni Award to TMA members **Max C. Butler, MD, Jack D. Ramsey, MD,** and, posthumously, **Rodolfo E. Margo, MD.** The award is the highest alumni honor bestowed by the School of Medicine.

A past TMA president, Dr Butler is a family practitioner in Houston and assistant clinical professor of family practice at The University of Texas Health Science Center at Houston. He has served as president of the Texas State Board of Medical Examiners, the Harris County Medical Society, and the Harris County Academy of Family Physicians. Dr Butler is an active member of the Federation of State Medical Boards of the United States, the National Board of Medical Examiners' United States Medical Licensure Examination Step III Test Committee, and is an alternate delegate to the American Medical Association.

Dr Ramsey has been chief of the division of radiation oncology at Hendrick Medical Center in Abilene since 1970. He is a past president of the board of trustees of the UTMB alumni association, the Cooley Radiological Society, and Radiology Associates of Abilene. Dr Ramsey serves on the Radiation Advisory Board at the Texas Department of Health, the TMA Radiation Advisory Committee, and the Texas Physician Advisory Committee of The University of Texas M.D. Anderson Cancer Center.

Dr Margo practiced ophthalmology in the Rio Grande Valley medical community for 20 years until his death in January 1988. He studied in Moscow under the renowned Dr Svyatoslave Fyodorov, a pioneer in the development of the intraocular lens used as implants in cataract surgery. Dr Margo served as president of the Texas Ophthalmological Association and as a member of its executive board of directors.

The fourth-year class at The University of Texas Medical Branch at Galveston chose **William Edward Chavey II** to receive the Gold-Headed Cane Award for 1992. The award, established in 1960, is presented each year to the graduating senior chosen by his or her classmates as the one who has best exemplified the ultimate in patient care.

J. Thomas Hutton, MD, director of the Parkinson Disease Research Center at Saint Mary of the Plains Hospital in Lubbock, was elected president of the Texas Neurological Society. Other elected officers include **Robert Fayle, MD,** Houston, president-elect; **James M. Killian, MD,** Houston, vice president; **Blake O'Lavin, MD,** Corpus Christi, secretary-treasurer; **C. Jack Fraim, MD,** Beaumont, member at large; and **B. Peyton Delaney, MD,** San Antonio, immediate past president.

The AMA Medal of Valor was awarded posthumously to **John Richard Laramore,** a student at The University of Texas Medical School at Houston who died from injuries sustained while struggling with a disoriented patient. The medal is given to AMA members who demonstrate courage under extraordinary circumstances in non-wartime situations.

Lubbock general surgeon **David E. Mangold, MD,** received a 3-year appointment as Cancer Liaison Physician for a local hospital. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

The National Alliance for the Mentally Ill presented **DeWayne K. Phillips, MD,** Bay City, with its Exemplary Psychiatrist Award during the American Psychiatric Association's annual convention in Washington.

Ray E. Santos, MD, Lubbock orthopedic surgeon and associate professor at Texas Tech University School of Medicine, has been elected president of the board of trustees of The University of Texas Medical Branch at Galveston School of Medicine Alumni Association.

Salwa A. Shenaq, MD, associate professor and director of cardiovascular anesthesia research at Baylor College of Medicine in Houston, has been elected to the board of directors of the Society for Cardiovascular Anesthesiologists.

Salwa A. Shenaq, MD

Please let *Texas Medicine* know about your honors and achievements.

Criteria for inclusion in the Newsmakers section are: TMA member; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, Texas Medicine, *401 W 15th St, Austin, TX 78701.*

Houston plastic surgeon **Melvin Spira, MD,** has been installed as president of the American Association of Plastic Surgeons. Dr Spira is professor and head of the division of plastic surgery at Baylor College of Medicine.

The Texas Orthopaedic Association Officers for 1992–1993 are **Clarence A. Temple, MD,** Paris, president; **Charles Kennedy, Jr, MD,** Corpus Christi, president-elect; **Joseph M. Abell, Jr, MD,** Austin, second president-elect; **Carey Windler, MD,** Austin, secretary-treasurer; **Phil H. Berry, Jr, MD,** Dallas, immediate past president; and **Raymond Bagg, MD,** El Paso, historian-membership chairman.

Nalin H. Tolia, MD

Odessa/Midland ophthalmologist **Nalin H. Tolia, MD,** was appointed by Gov Ann Richards to serve on the District Three Review Committee of the Texas State Board of Medical Examiners.

OBITUARIES

Robert M. Arledge, MD, 79; San Angelo; The University of Texas Medical Branch at Galveston, 1941; died May 16, 1992.

Robert T. Blair, MD, 71; Pasadena; University of Cincinnati College of Medicine, 1950; died May 15, 1992.

Robert Louis Brien, MD, 55; Dallas; The University of Texas Southwestern Medical School, 1962; died May 25, 1992.

Don W. Freeman, MD, 83; Denison; Harvard Medical School, 1934; died May 13, 1992.

Jack R. Gordon, MD, 64; Coldspring; The University of Texas Medical Branch at Galveston, 1957; died April 25, 1992.

William Newell Harkness, Jr, MD, 65; Garland; The University of Texas Southwestern Medical School, 1959; died June 1, 1992.

Robert L. Harrison, MD, 45; Galveston; The University of Texas Medical Branch at Galveston, 1976; died May 21, 1992.

George V. Launey, Jr, MD, 81; Granbury; Tulane University, 1938; died May 15, 1992.

Joe D. Nichols, MD, 83; Atlanta; University of Arkansas School of Medicine, 1933; died May 27, 1992.

William S. Reynolds, Jr, MD, 75; Dallas; University of Louisville School of Medicine, 1942; died May 14, 1992.

Clyde E. Thomas, Jr, MD, 78; Big Spring; The University of Texas Medical Branch at Galveston, 1937; died May 14, 1992.

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Defending Defensible Doctors

Legislative Affairs

TMA president stresses importance of "sunset" process

TMA President William G. Gamel, MD

The most important piece of legislation affecting physicians likely to be enacted in 1993 probably will not be a health-care reform plan. And it probably won't be changes in Medicare reimbursement, clinical laboratory regulations, new HIV infection control requirements, or even medical liability. The legislation with the greatest potential to profoundly affect how doctors practice medicine in Texas is the legislative, or "sunset," review of the Medical Practice Act and the Texas State Board of Medical Examiners.

That process, which begins in earnest this fall, will bring intense scrutiny of the operations of the State Board of Medical Examiners and the laws regulating medical practice. Adding even greater importance to the sunset process is the fact that 13 other agencies that license chiropractors, dentists, nurses, physical therapists, and other allied health professionals also will be under review.

Texas Medicine *sat down recently with Texas Medical Association President William G. Gamel, MD, Austin, and talked about the implications sunset review will have for physicians and their patients.*

Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs section of* Texas Medicine.

TM: Most physicians probably have heard of the sunset review process but really do not know how it works or what it portends for the medical profession. Can you explain the importance of this process for the practice of medicine in Texas?

Dr Gamel: Simply put, the sunset process is the automatic termination of the State Board of Medical Examiners, which licenses physicians and polices the practice of medicine. Each state agency must go through sunset review every 12 years and rejustify its existence to the legislature.

The commission, made up of lawmakers and public members, makes recommendations to the legislature about whether agencies are operating effectively and whether they should be reauthorized, abolished, or reorganized in some way. If legislation is not passed to reauthorize an agency, it automatically repeals, or "sunsets." So, unless we have a new law by the end of the 1993 session, anyone can hang out a shingle and practice medicine — there will be no Board of Medical Examiners.

> "SUNSET OPENS UP THE MEDICAL PRACTICE ACT TO EVERY CONCEIVABLE AMENDMENT, WHETHER IT BE HELPFUL OR HARMFUL."

TM: Is it likely that a new Medical Practice Act will not be passed?

Dr Gamel: No, the legislature will not let the Medical Practice Act expire, although a special session was required to complete a bill in the previous sunset cycle in 1981. Protection of the public health demands that a strong Medical Practice Act remain in place. However, the process will be very contentious, with the various allied health groups and other special interests seeking to expand their scope of practice. That's the real implication for medicine — sunset opens up the Medical Practice Act to every conceivable amendment, whether it be helpful or harmful. We already have one of the strongest sets of laws governing the practice of medicine in the country. Our challenge will be to do all we can to ensure the highest quality of medical care and protect public health. That will be made doubly difficult because we not only will be dealing with the physicians' licensing act but also those of nurses, chiropractors, physical therapists, dietitians, optometrists, pharmacists, and several others.

TM: Will Texas Medical Association oppose all changes that might be proposed to the Medical Practice Act?

Dr Gamel: No, some changes are needed. We can improve the act and improve the quality of medicine practiced under it, but a very good rationale for any proposed changes must exist. Physicians have to look out for all those groups that want to practice medicine without going to medical school. Their arguments will revolve around cost issues and access to care in underserved areas. In fact, statistics show that, if anything, expanding the scope of practice for these groups will increase costs because it is just another mandated benefit.

There's no guarantee that nurse practitioners would go into underserved areas. They're not there now,

yet they want "equal pay for equal work." Even if the care were comparable, which it might be in only limited circumstances, they can no more defy the laws of economics than we can. That doesn't even speak to the quality issues —the judgment and training it takes to practice medicine. We have a responsibility to uphold a high standard, and doctors of medicine and osteopathy can't abrogate that responsibility.

TM: Which allied health groups do you anticipate will try to use the sunset process to expand their scope of practice?

Dr Gamel: Nurse practitioners, certified registered nurse anesthetists, psychologists, chiropractors, physical therapists, and optometrists. We expect all these groups to seek changes in their respective acts to expand scope of practice. Nurse practitioners and nurse anesthetists will be seeking independent practice and direct reimbursement. Chiropractors and psychologists will be seeking expanded scope of practice, and the optometrists will be trying to build on the authority to use diagnostic and certain therapeutic drugs that they gained in the past session. Already they have attempted to promulgate rules through their own board that are in direct violation of that statute. Their rule literally expands them into all classes of drugs, instead of the specific medications outlined in the law.

"WE NEED TO ENSURE THAT REVENUE GENERATED FROM PHYSICIAN LICENSE FEES GOES BACK TO THE BOARD, NOT TO THE STATE GENERAL REVENUE FUND."

TM: One of the most important provisions of the Medical Practice Act, both for the medical profession and public health, is the prohibition against the corporate practice of medicine. Do you expect that provision to come under attack in 1993?

Dr Gamel: I think that some hospital corporations, particularly the large urban hospitals, would like to see the prohibition against the corporate practice of medicine repealed. If successfully repealed, it would give hospitals more revenue, more control over who admits patients and more influence over the care patients receive. Physicians have got to see to it that the prohibition is maintained. We do not want quality of care issues left up to some corporate entity. Fortunately, TMA and Texas Hospital Association have an excellent working relationship.

TM: What would be the impact on physicians if the prohibition were repealed?

Dr Gamel: Worst case, our patients could be at the mercy of the less virtuous hospital corporations. Physicians could have their choice of hospitals for patient admissions limited and their ability to make the best treatment decisions for each individual patient restricted. We have already seen the patient consequences of a corporate model demonstrated by the recent psychiatric hospital scandals.

TM: Continuing medical education as a condition of relicensure has already surfaced in the sunset process. Lawyers imposed a 15-hour continuing legal education requirement during State Bar sunset; pharmacists and registered nurses have similarly already imposed modest continuing education requirements. Do you think similar requirements also will be applied to physicians in 1993?

Dr Gamel: That is an issue we must be prepared to address. We're the last of the learned professions not to have it, and we easily could get painted into a corner trying to defend any opposition to mandatory CME. It really isn't fair for us to be held to a different standard. At the same time, the Medical Practice Act already holds physicians to extremely high standards of training and competence, higher than those groups that are subject to mandatory continuing education. And the vast majority of physicians — well over two thirds — already participate in continuing medical education on a voluntary basis or as a condition of maintaining their board certification.

TM: On the positive side, you said the Medical Practice Act can be improved in some areas. What amendments will TMA seek during the sunset process?

Dr Gamel: As I said before, we already have one of the strongest acts in the nation. Some of the problems we've experienced with the Board of Medical Examiners have not been with its authority under the law but with the funding it has received. We need to ensure that revenue generated from physician license fees goes back to the board, not to the state general revenue fund. The board needs the funding to maintain a well-trained investigative staff. Be-

cause of low pay, turnover has been high. And the board has been unable to hire a large or experienced enough legal staff to keep up with its caseload. All of this is happening at the same time that the number of reciprocity applications from out-of-state physicians has risen way ahead of normal levels.

Also, I think we certainly need to look at the peer review process. I think it's important that we improve the ability of physicians to police themselves.

Settlement reached in psychiatric hospital case

A MAJOR FOR-PROFIT psychiatric hospital chain has agreed to make sweeping changes in its operations as part of a settlement reached with Texas Attorney General Dan Morales in a case stemming from alleged violations of a law initiated and written by Texas Medical Association in 1991.

Meanwhile, a Senate select committee is drafting legislation for consideration in 1993 to address other psychiatric hospital problems.

The settlement with National Medical Enterprises was announced June 3. An NME subsidiary, Psychiatric Institutes of America, operates eight inpatient facilities in Texas.

Attorney General Morales sued PIA and its Fort Worth facility for violating a new state law prohibiting the payment of kickbacks for referral of potential patients. That law, passed by TMA, was enacted after disclosure that a San Antonio psychiatric hospital paid a private security firm to pick up a teen-age boy against his parents' wishes.

The settlement prohibits PIA hospitals from admitting any minor under age 10 without a second medical opinion unless the initial diagnosis was made by a physician certified in child psychiatry, admitting any patient without an evaluation by a licensed psychiatrist within the previous 72 hours, and placing PIA Group compensated referral representatives in Texas public schools to provide counseling services. It also prohibits the hospitals from engaging in any form of patient solicitation or counseling without clearly disclosing affiliation with the PIA

Preliminary reform recommendations released by task force

INCREASED EMPHASIS ON PREVENTIVE CARE, a broad list of essential medical services, and full funding for a statewide trauma system are among the preliminary recommendations of the Texas Health Policy Task Force.

The preliminary recommendations were released May 28 by four task force subcommittees and now are under review by the full panel. A draft task force report is expected to be released for public comment Aug 24, with the panel scheduled to meet Sept 25 to finalize the recommendations that will be presented to the 73rd Legislature next year.

Speaking to the special Texas Medical Association Health Policy Advisory Panel in June, Albert Randall, MD, Austin, said the recommendations likely will undergo considerable change before the full task force report is issued later this month.

"This (May 28) was the first time the full task force heard each of the subcommittee's reports," said Dr Randall, a member of the task force research staff.

Richard Barry, MD, Odessa, a task force member and chairman of the subcommittee on cost containment, also described the reports as "documents in evolution."

The subcommittee reports contain several recommendations TMA has supported for some time. The report of the task force subcommittee on availability recommends funding of the statewide trauma system authorized under the Omnibus Health Care Rescue Act of 1989. TMA was instrumental in passage of that act and has since lobbied for funding for the trauma system.

The same subcommittee also recommended increased funding for third-year medical clerkships, increased support for family practice residency programs, and use of incentives to recruit more applicants into family practice programs, including loan forgiveness and stipend programs.

However, the reports also include far-reaching proposals that could dramatically change the face of health care in Texas and that caused great concern among members of the TMA advisory panel.

Among the recommendations are proposals to consolidate licensing of all health-care personnel under one agency; to pay allied health personnel the same fees as physicians (for example, paying a midwife the same fee an obstetrician would receive for attending a normal birth); to allow advanced nurse practitioners to independently prescribe certain drugs; to require providers to disclose fees and patient outcomes to promote competition in the health-care marketplace; and to initiate steps to adjust the supply and distribution of physicians and limit specialty enrollments.

The TMA advisory panel, appointed by President William G. Gamel, MD, Austin, and chaired by former President Max C. Butler, MD, Houston, has suggested the TMA division of public affairs submit a written response to the task force. That response was being drafted at *Texas Medicine* press time, but was expected to emphasize the association's support for preliminary recommendations that are consistent with TMA objectives and clarification on the intent of others. TMA advisory panel members were enthusiastic about a recommendation to expand access to care through school-based programs, but questioned issues such as expansion of practice and equal reimbursement for mid-level practitioners.

All articles in Texas Medicine *that mention Texas Medical Association's stance on state legislation are defined as "legislative advertising," according to Tex Govt Code Ann §305.027. That law requires disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in* Texas Medicine: *Robert G. Mickey, Executive Vice President, TMA, 401 W 15th St, Austin, TX 78701.*

Group and providing any form of training or incentives to PIA Group employees for engaging in "quota" or "bed-packing" activities.

The hospital chain agreed to several other restrictions. It also agreed to pay $1.1 million in investigative costs, to drop as much as $4.9 million in claims against the state Crime Victims Compensation Fund, and to provide $2.6 million in charity care.

Both TMA and the Texas Society of Psychiatric Physicians (TSPP) applauded the settlement saying it will ensure that patients receive adequate and appropriate care at the eight psychiatric hospitals.

Both organizations also have been monitoring closely the activities of a special Senate Interim Committee on Health and Human Services that has been investigating problems at for-profit psychiatric hospitals.

The committee's investigation grew out of the same circumstances that prompted passage of the anti-kickback legislation. Chaired by Sen Mike Moncrief, Fort Worth, the committee has identified 33 issue areas on which it intends to recommend legislation in the 73rd Legislature in 1993.

Bills already have been drafted addressing 24 of those issues, including requests to be released from patients who were voluntarily admitted, patients' bill of rights, itemized billing statements, patient abuse, whistle-blowers' protection, criminal penalties, private psychiatric hospital standards, intake and assessment of patients, insurance fraud, and utilization review.

Still to be addressed are illegal remuneration, voluntary admissions, licensure fees, inappropriate intimate relations between mental health professionals and patients, and rights of minors.

Some of these areas already have been addressed in rules implemented in recent months by the Texas Department of Mental Health and Mental Retardation and Department of Health, including the patient bill of rights, release of voluntary patients, and evaluation of patients by physicians prior to admission.

Psychiatrists are concerned that the committee may actually loosen the requirement that a physician evaluate patients before admission.

"Psychologists have insisted they have the right to admit patients to psychiatric hospitals and claim that's something they've done for some time," said Spencer Bayles, MD, Houston, a TMA member and chairman of the TSPP Governmental Affairs Committee. "It is the opinion of TSPP, and concurred in the Department of Mental Health and Mental Retardation, that the Texas Mental Health Code clearly says a patient must be examined by a physician before being admitted."

Raiford named human services commissioner

BURTON RAIFORD, A 23-YEAR veteran of the Texas Department of Human Services, has been selected as that agency's commissioner.

The decision to hire Mr Raiford for the commissioner's job was made June 18 by the TDHS board. He had served as acting commissioner since the resignation of Ron Lindsey a year ago.

As commissioner, Mr Raiford will oversee an agency with 18,000 employees and a $8.2 billion annual budget. Among the agency's responsibilities is the Texas Medicaid program. ★

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Current Medical Specialty(ies)

Former Medical Specialty(ies) (for past 10 years)

List surgical procedures routinely performed

State(s) where currently licensed

States where formerly licensed (for past 10 years)

Amount of Professional Liability Insurance now carried
$

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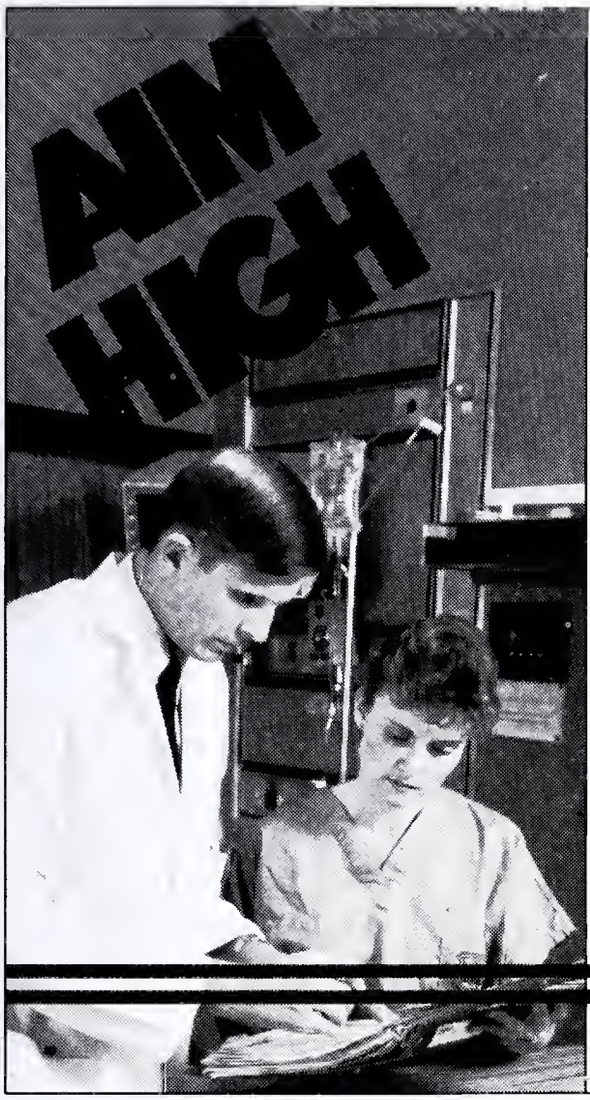

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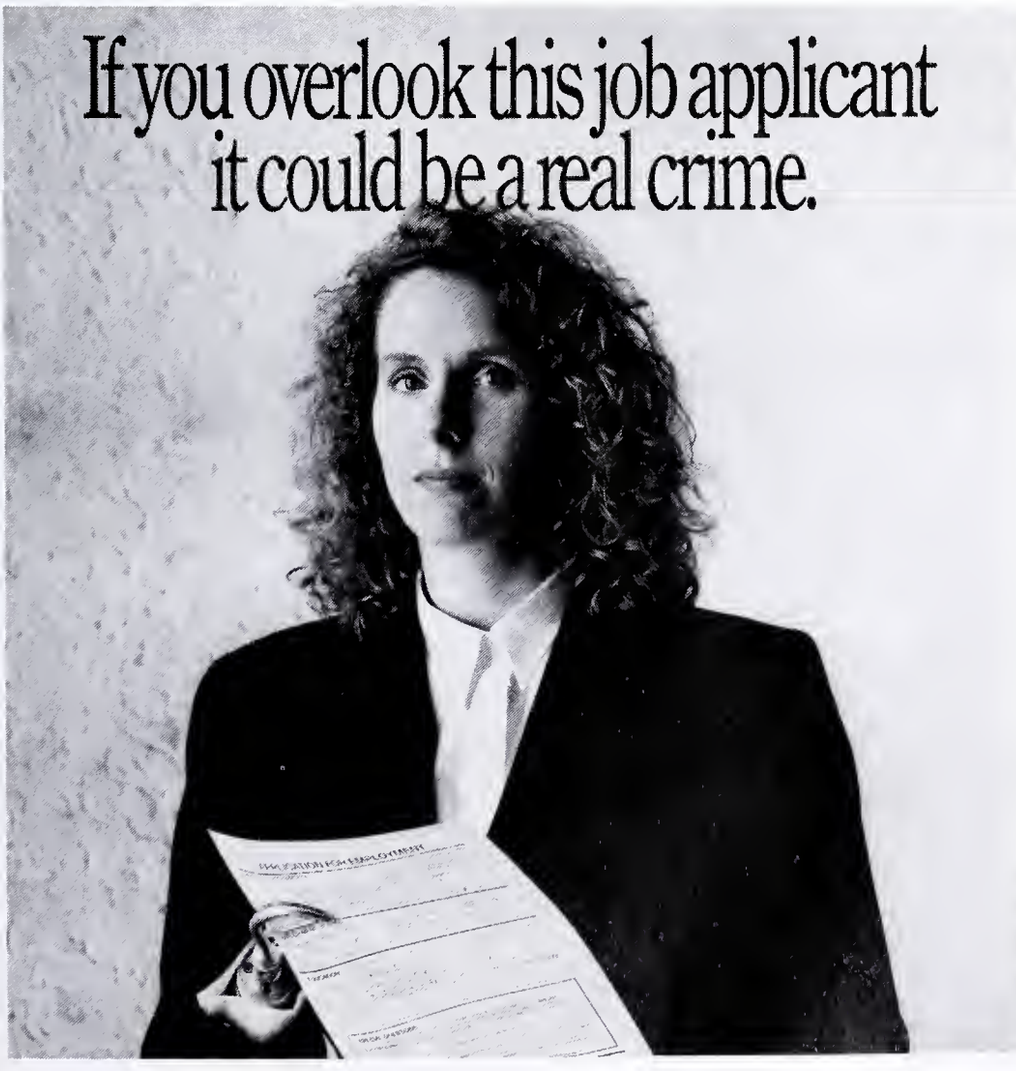

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Medical Economics

Managed care hassles not only frustrating, but expensive

THE HASSLES REPEATEDLY faced by physicians and their staff in dealing with managed care plans, Medicare, Medicaid, and Workers' Compensation claims frustrate their ability to provide quality health care for their patients. But, according to TMA's Division of Medical Economics, they are also downright expensive.

According to an analysis of more than 500 "Hassle Factor Log" sheets submitted to TMA since October 1990, the average hassle costs $241 per day for the physicians dealing with it.

"This shows how much expense is added to the health-care system by unnecessary regulation," said David Marcus, PhD, TMA director of health-care financing. "It is one of the more obvious reasons that the cost of health care continues to climb."

TMA's Hassle Factor Log (see p 31) is a convenient way for physicians to document time-consuming, bureaucratic problems that public and private insurers, government agencies, and review companies impose on medical practices.

"Physicians who take the time to fill out the log and send it to us are not just adding to a database," Dr Marcus said. "We take these problems directly to the carrier through a series of face-to-face meetings and try to get them resolved."

TMA began this series of negotiations with insurers and government agencies in 1991 and has been able to resolve a large number of disputes between physicians and their carriers.

The hassles cited most often on the logs were denial of payment, requests for patient information, medical necessity review, reduction of billed charges, and precertification of services. Often, medical offices cited complex situations involving multiple problems and considerable staff time. Each hassle required more than two physician or staff responses.

> "THIS SHOWS HOW MUCH EXPENSE IS ADDED TO THE HEALTH-CARE SYSTEM BY UNNECESSARY REGULATION."

The figure of $241 per hassle per day is based on a valuation of the average physician and staff times required to solve the problem and does not include overhead costs. A problem serious enough to generate a hassle log consumed 6.5 hours of staff time valued at $10 per hour and 2.5 hours of physician time at $70 per hour.

"The overall picture we get from these hassle logs is a consistent, though badly disorganized and often intrusive, effort at cost containment," Dr Marcus said. "The net effect is a clear picture of the scales of cost and quality disturbingly unbalanced on the side of cost containment."

He adds that TMA is using the information gleaned from the hassle factor logs to document and strengthen its case that bureaucratic interference in medical practices is offensive, harmful to patients, and expensive.

In addition to the hassle factor initiatives, TMA is also working with the AMA to pursue anti-hassle legislation, has a mini-consultation program through county medical societies to assist physicians, sponsors letter-writing campaigns during comment periods for proposed federal regulations, and works one-on-one with legislators and members of Congress to promote health-care concerns.

For more information on TMA's hassle factor initiative or other programs, contact the TMA Health Care Financing Department at (800) 880-1300 or (512) 370-1414.

How much will CLIA cost your office?

MANY TEXAS PHYSICIANS are making decisions about their laboratory operations, thanks to the Clinical Laboratories Improvement Amendments (CLIA) of 1988, which become effective September 1, 1992. And, although most physicians will not make their decisions based solely on the cost of a CLIA certificate, they want to know the impact on their business operations of these fees and other costs related to compliance.

According to Donna Kinney, TMA physician practice specialist and primary CLIA resource person, the main choices a physician who has been testing specimens can make and stay within the provisions of the law at this time are:

- Stop all in-office testing.
- Limit testing to qualify for a waiver.
- Continue testing and comply with CLIA requirements.

If a physician decides to stop testing by September 1, 1992, nothing further must be done to comply with

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

CLIA. However, no one in the physician's office may legally perform any tests at all, including microscopic examinations of any types of specimens taken from the human body. The physician would have to secure a certificate before performing even one such test.

For a physician who decides to limit testing to waived tests (see the list of those tests in *Texas Medicine*, June 1992, p 23), a certificate will cost $100 every 2 years. Staff will be required to follow manufacturer's instructions for all tests, and the physician must notify the Health Care Financing Administration within 30 days of a change in ownership, name, location, or director.

IF A PHYSICIAN DECIDES TO STOP TESTING BY SEPTEMBER 1, 1992, NOTHING FURTHER MUST BE DONE TO COMPLY WITH CLIA.

Because the list of waived tests is very limited and does not include many commonly performed tests like CBCs, strep screens, or wet mount microscopic examinations, many physicians have decided to continue performing what HCFA has designated as "moderate complexity tests." In this case, the initial registration fee will probably be $100. The office will be subject to an unannounced inspection every 2 years, and the inspection will cost $300 or more. Additional costs for complying with CLIA regulations include the following:

- Test recording and reporting procedures may need to be altered to meet CLIA standards.
- Some information about test methodologies will have to be made available to patients upon request.
- The laboratory will have to create a procedure manual or possibly revise an existing one to include all required information.
- Equipment calibration procedures will have to be performed and documented every 6 months.
- Two levels of control procedures will be required, if applicable, for each day of testing.
- Specific control procedures will be required for tests in some specialties.
- All staff will have to be assigned to roles specified by the regulations and will have to meet the qualifications specified for those roles. All testing personnel will be required to have a minimum of a high school diploma or equivalent.
- Although proficiency testing will be required, physician office laboratories will not need to enroll until January 1994.

These are only some of the requirements for compliance or documentation in the CLIA regulations. Physicians who intend to continue testing need to be in compliance with these standards by the time of their first inspection, which could occur sometime in 1993.

Publications and workshops will be available through TMA this fall to assist physicians in complying with CLIA. For more information, contact Ms Kinney at (800) 880-1300 or (512) 370-1422.

HealthFind Exchange program planned in September

THE CENTER FOR RURAL Health Initiatives is planning its 1992 HealthFind Exchange, a program to match rural Texas communities with prospective physicians, September 26–27, 1992, in Fort Worth.

The program consists of two parts: recruiting and training communities seeking a physician, and the Exchange, which matches physicians with communities. At the Exchange, each community will have a booth to provide information about its town, discuss recruitment incentives, and answer questions from physicians. Participating communities must be designated as rural and have a population less than 30,000. The exchange is limited to 50 communities.

Representatives from many of the communities planning to participate in the Exchange in September have attended one of a series of workshops during April, May, and June. The workshops, held in Amarillo, Nacogdoches, Odessa, Corpus Christi, and Austin, provided community leaders with information on how to recruit a physician and market their communities.

The program is based on the health-care needs of rural communities in Texas. The state currently has 159 health professional shortage areas, and 18 counties have no physicians. The Fall 1991 Exchange, with a pool of approximately 50 mostly second- and third-year residents, matched five physicians with recruiting communities, with three more physicians and communities in negotiations at press time.

The HealthFind program is cosponsored by the Texas Academy of Family Practice, Texas Higher Education Coordinating Board, Texas Hospital Association, Texas Department of Health, Texas Organization for Rural and Community Hospitals, Health Care Options for Rural Communities, and Texas Medical Association.

The 1992 program will be held at the Worthington Hotel from 10 am Saturday, September 26, to 3:30 pm Sunday, September 27. Registration, $30 for resident physicians and $125 for practicing physicians, includes hotel room Saturday night for physician, spouse, and children, two luncheons, a reception and breakfast for physician and spouse, child care and meals for the children, and a continuing medical education seminar.

The registration deadline for prospective physicians is September 4. For more information, contact Carol Peters, Texas Center for Rural Health Initiatives, at (512) 479-8891, or at PO Drawer 1708, Austin, TX 78767.

Placement service announces new fee schedule

THE TEXAS PHYSICIAN PLACEMENT SERVICE, a joint venture of the Texas Medical Association and the Texas Academy of Family Physicians, has announced a revised fee schedule for practices seeking a physician.

The program matches practice opportunities with physicians seeking a position, based on practice specialties, community interests, and other criteria.

A single fee will replace the two-tiered structure that consisted of a registration fee and a placement fee. Fees are now just $250 for TMA and TAFP members and $300 for nonmembers. The fees entitle practice opportunities up to 12 months participation in the service.

"This makes our computer-assisted program even more cost-effective to physicians, hospitals, and communities seeking to recruit a physician," said Mildred Bell, program administrator, who added that a discount rate applies for listing additional practice opportunities.

The service is free to physicians seeking a practice location.

For more information, contact Ms Bell at TMA at (800) 880-1300 or (512) 370-1403.

Medicare to add preventative services at health centers

MEDICARE IS PROPOSING expanded access to a broad range of preventative healthcare services by paying for those services when they are performed by federally approved community health centers.

According to Health and Human Services Secretary Louis W. Sullivan, MD, under new regulations community health centers will begin providing annual physical examinations, screening and diagnostic tests for detection of vision and hearing problems and other medical conditions, as well as administering influenza and other vaccines.

According to the Texas Association of Community Health Centers, there are 29 federally approved community and migrant health centers in the state, with the majority located in South Texas, the Rio Grande Valley, and the Panhandle. Nationwide, HCFA said, there are about 550 community and migrant health centers qualified to deliver such services.

The new Medicare benefits are authorized by OBRA '90 and will cost the Health Care Financing Administration (HCFA) an estimated $30 million in fiscal 1992, increasing to $55 million in 1996.

Until recently, Medicare-covered services were limited to the diagnosis and treatment of illness and injury. By law, Medicare could not pay fees for routine physical examinations, although HMOs under contract to Medicare have been providing a variety of preventative services.

However, HCFA within the past 2 years has implemented legislation to provide Medicare payments for screening Papanicolaou smear tests and screening mammography examinations. In community health centers, Medicare will pay for mammography and Papanicolaou smear tests if the centers are certified to conduct such tests.

Comments on the regulations should be submitted by August 11, 1992, to Health Care Financing Administration, Attention: BPD-728-FC, PO Box 26676, Baltimore, MD 21207.

For the location of the nearest federally approved health center, contact the Texas Association of Community Health Centers at (512) 454-4583. ★

TMA HASSLE FACTOR LOG

Physician or clinic name _____ **Date** _____

Contact person _____ **Title** _____

Address _____ **Phone number** _____

Company/individual/agency causing hassle _____

Brief description of hassle _____

_____

_____

_____

_____

Is this the first time this problem has occurred or is it a recurring problem? ☐ First Time ☐ Recurring Problem

Subject of hassle:

- ☐ Medical necessity review
- ☐ Quality review
- ☐ Length of stay dispute
- ☐ Precertification of services
- ☐ Referral
- ☐ Problem with terms of HMO/PPO contract
- ☐ Request for information about a patient
- ☐ Denial of payment
- ☐ Reduction of billed charges
- ☐ Recoding of services
- ☐ Other _____

Did this hassle cause the physician or staff to take any of the following actions?

- ☐ Make telephone call(s) How many? _____ Time spent on phone_____
- ☐ Write letter and/or narrative report
- ☐ Resubmit claims
- ☐ Seek outside assistance. If so, from whom?_____
- ☐ Retrieve and review office medical records
- ☐ Retrieve and review hospital medical records
- ☐ Copy and send medical records, progress notes or operative report(s)
- ☐ Consult with colleagues

Can you estimate the total time involved in dealing with this hassle? Staff time _____ Physician time _____

May TMA contact you for additional information? ☐ Yes ☐ No

Please add any additional information you think would be helpful in documenting the nature of this hassle and/or its impact on your medical practice.

_____

_____

_____

_____

Return completed form to TMA Department of Health Care Financing, 401 W 15th St, Austin, TX 78701.

Public Health

Health commissioner stresses need for preventive care

During the last 4 months, Texas Department of Health (TDH) Commissioner David R. Smith, MD, has certainly not been timid about voicing his views. The 38-year-old pediatrician, who was selected in February to head TDH, says the greatest threat to public health is the failure to recognize the value of prevention. In an interview with Texas Medicine, *Dr Smith discussed public health concerns in Texas and the valuable link between private physicians and the health department.*

"TDH HAS TO HAVE A partnership with private physicians," says Dr Smith. "Their voice of advocacy for reform and financing of preventive services is most important."

Dr Smith admits all the answers will not come from his department. It will take a Texas Medical Association and TDH coalition to bring change, he says. "The message is, we can't get this done without support from private physicians."

Issues that have grabbed the commissioner's attention since his appointment in February include educating physicians on preventive health care, developing a regional trauma care system, and recognizing the signs of family violence.

"It's tough in many parts of the state for family practitioners, and we don't always realize the difficulties," he says. Physicians, both urban and rural, face loneliness, lack of support, lack of referral basis,

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

THE HEALTH COMMISSIONER'S VIEWS

Texas Department of Health (TDH) commissioner David R. Smith, MD, commented recently on a host of public health issues:

Tobacco and alcohol

"These are the biggest killers. We market pain and suffering better than prevention. Our annual budget for tobacco prevention is $133,000. California has a $7 million budget for prevention. We are not even bailing the boat out. It is sinking."

Immunizations

"If we can't fix measles, then we probably can't fix anything. Vaccine should be provided free to all practitioners. A vaccine access act should be drafted in Texas to recognize that everyone should be vaccinated."

Teen pregnancy

"Texas leads the nation in the youngest age group of teens who become pregnant. This is not something we should be proud of. Public health messages are not always delivered in the right setting. School-based health care needs to be considered."

Sex education

"This is a difficult issue on the emotional side. It is much clearer on the factual side. The fact is a large percentage of our kids are sexually active by the time they leave high school. I would love to see the message of abstinence delivered and received. But given the fact the cow is out of the barn, then we want to try and save lives. There needs to be meaningful discussion about sex, and this includes the use of condoms. I know this makes people nervous, but facts are facts. Knowledge does not create promiscuity. I'd like to see some changes on what we see on the movie screens and television. We need to start being critical about what is going on. The health department is trying to save these kids' lives who are already sexually active."

AIDS and HIV

"HIV is not ignoring teens and teens can't ignore HIV. I don't want to lose part of a generation to HIV."

Nursing homes

"If patients are not getting care, then I am going to have to ask some real serious questions. I'm always going to be on the side of the patients. There has been a lot of emotion and energy created concerning the condition of nursing homes in Texas. TDH has been working with TMA through leadership groups to better define the role of medical directors. This ties in with quality assurance controls like the ones used in hospitals and private practice."

Trauma care

"We have to look at a strategy for trauma care in Texas. This is an area of health care that everybody understands from upper to lower class and rural to urban populations."

Family violence and child abuse

"Physicians are in the position to intercede in order to recognize and prevent family violence and child abuse. There is not a lot of capacity in the private or public sector to address these needs, and the health-care team is going to have to be broadened."

AGENDA ON AIDS

Physicians and AIDS education

Seventy-six percent of parents responding to an Eastern Virginia Medical School survey expressed a desire for their children to receive AIDS education from a physician. Data also revealed that only 22% of the adolescents reported they had learned anything about AIDS from a nurse or physician.

AIDS campaign targets heterosexuals

Sexually active non-monogamous heterosexuals are the focus of a Texas Department of Health public service AIDS campaign. The campaign emphasizes the "geometric" nature of sexual risk. The campaign also concentrates on the "it doesn't apply to me" denial syndrome that reflects a belief held by many heterosexuals.

AIDS commission changes meeting to October

A public hearing scheduled to be held in Austin in July by the National Commission on AIDS has been changed to October. Physicians interested in the hearing can contact the commission at (202) 254-5125.

I believe one of my patients is at high risk of being infected with HIV. She refuses to be tested saying that because the disease is always fatal, it will not do any good to be tested. It seems to me she has a point. Does she?

Within the last 3–4 years new treatments have greatly increased both survival time and quality of life for HIV-infected individuals. Many of these treatments are prophylactic in nature and seem to be most effective when given to presymptomatic HIV-positive individuals. New drugs or new uses for existing drugs are discovered on a monthly basis. Research into this disease has made it one of the most rapidly advancing areas of medicine. Many HIV clinicians are beginning to think of HIV infection as a manageable, chronic disease like diabetes or hypertension.

Richard M. Grimes, PhD, director of the AIDS Regional Education and Training Centers for Texas and Oklahoma at The University of Texas at Houston School of Public Health, will provide answers to questions about AIDS each month in this column. For further information about this topic or any HIV topic, call the AIDS Helpline for Health Professionals at (800) 548-4659.

and other issues unique to the state, Dr Smith says.

He also says the issue of prevention needs to remain on the forefront and should be addressed in the medical education system.

"The answers to the problem are in the community," says Dr Smith. "Health-care reform is frustrating right now. Everyone has a sense of what the problems are, but we haven't gotten a lot of answers to specific solutions that we can implement. We have to pay attention to strategies and interim tactics that could make a difference in the short run while we are looking at long-term solutions."

Dr Smith calls TMA's public health package "aggressive," adding he doesn't know of many state medical associations that have the same direction in this area.

"There has been a clear recognition in the value of integrating the delivery of primary care and medical service in order to link that approach to prevention in the public health sector," says Dr Smith.

Within his own department, Dr Smith says the big challenge is communication. He wants the department to work on a horizontal mode as opposed to a vertical system.

"I want the department to think of the people we serve as consumers," says Dr Smith. "My greatest concern is that the patient/consumer is not getting the available services and is unable to voice his or her concerns."

Work groups consisting of TDH employees have been created to tackle agency-wide problems. TDH customers and clients also will have access to a consumer affairs office that will have an 800-number.

"The department wants to get feedback and find out what kind of job we are or aren't doing," he says, adding that he will continue his open-door and open-dialogue policy.

"I want what is best for the patients," Dr Smith says.

CME course focuses on team approach to cancer detection

PHYSICIANS CAN LEARN HOW to develop an in-office cancer and prevention center during a program scheduled August 29 in El Paso.

The program, Cancer Screening Skills: A Team Approach, focuses on breast and cervical cancers; techniques to help patients stop smoking; and the office-based cancer detection system, "SPOT" Your Cancer Risk.

Sponsored by Texas Medical Association's Physician Oncology Education Program, Nurse Oncology Education Program, Texas Tech University Regional Academic Health Sciences Center at El Paso, The University of Texas at El Paso College of Nursing and Allied Health, and the American Cancer Society, the course is designed for physicians and nurses.

To register, contact Corin De Garmo at (915) 545-6527. ★

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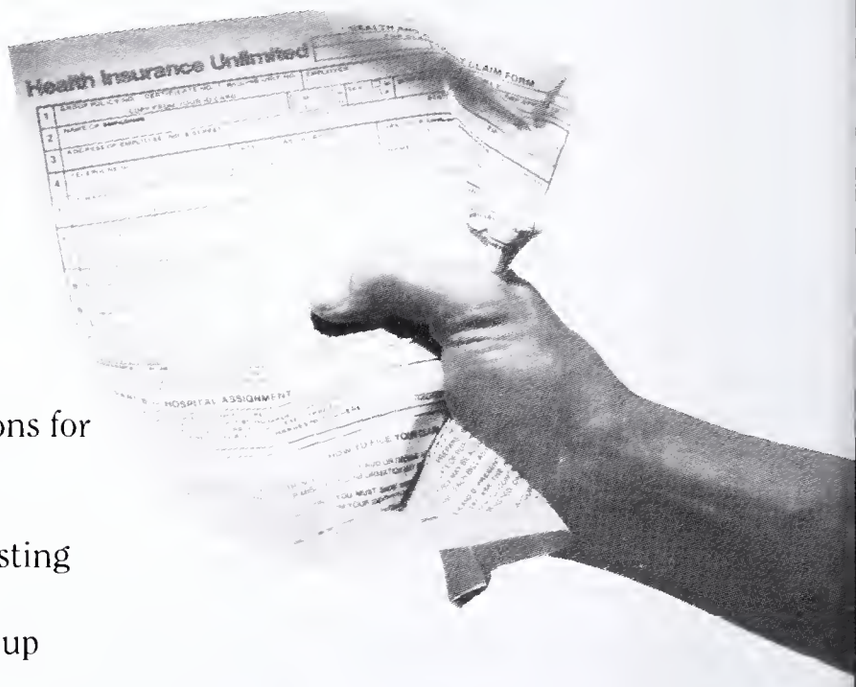

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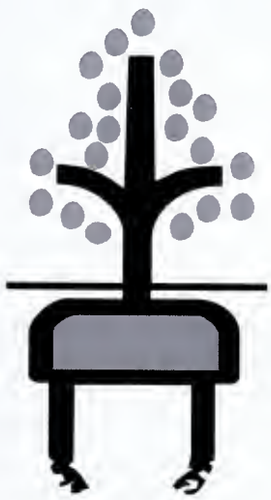

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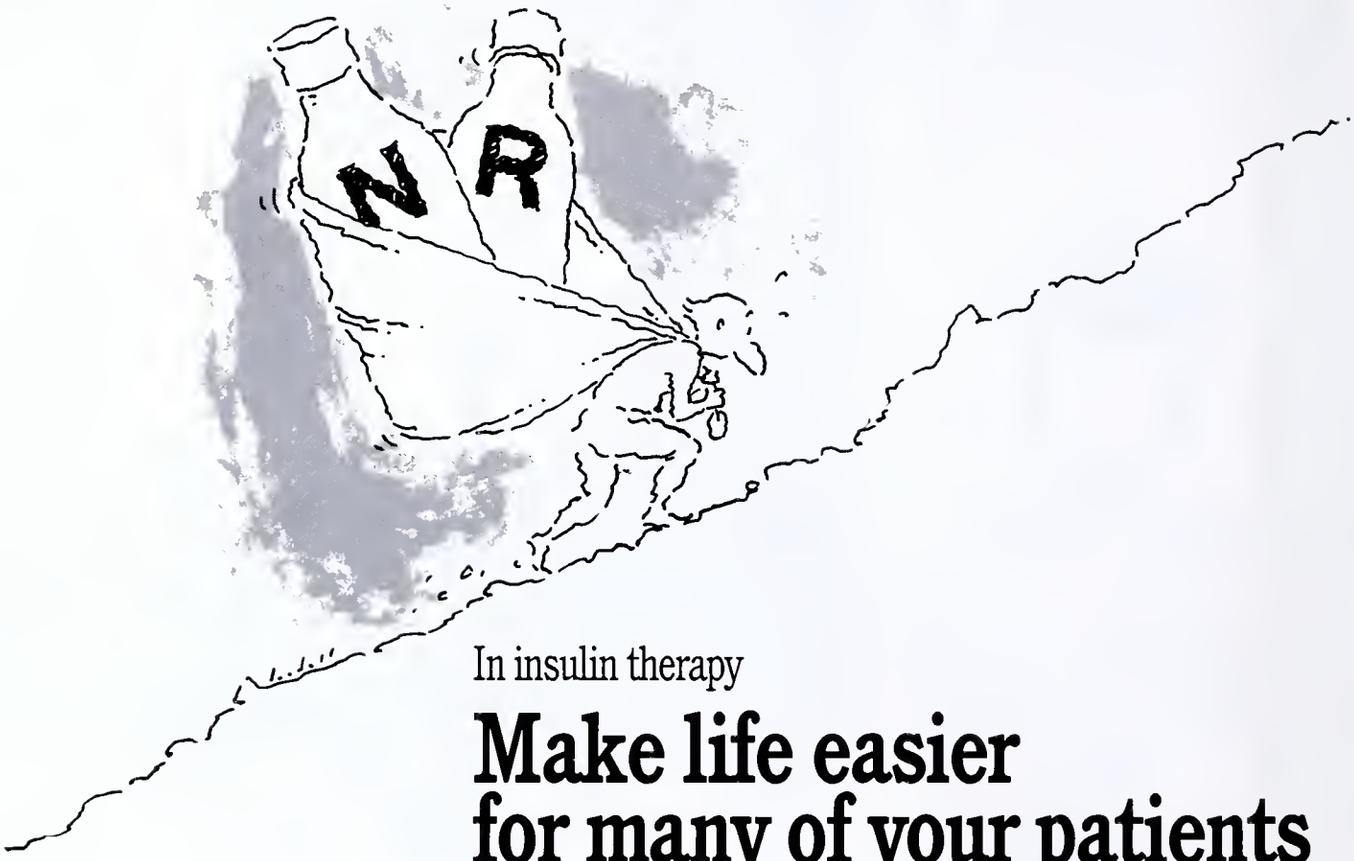

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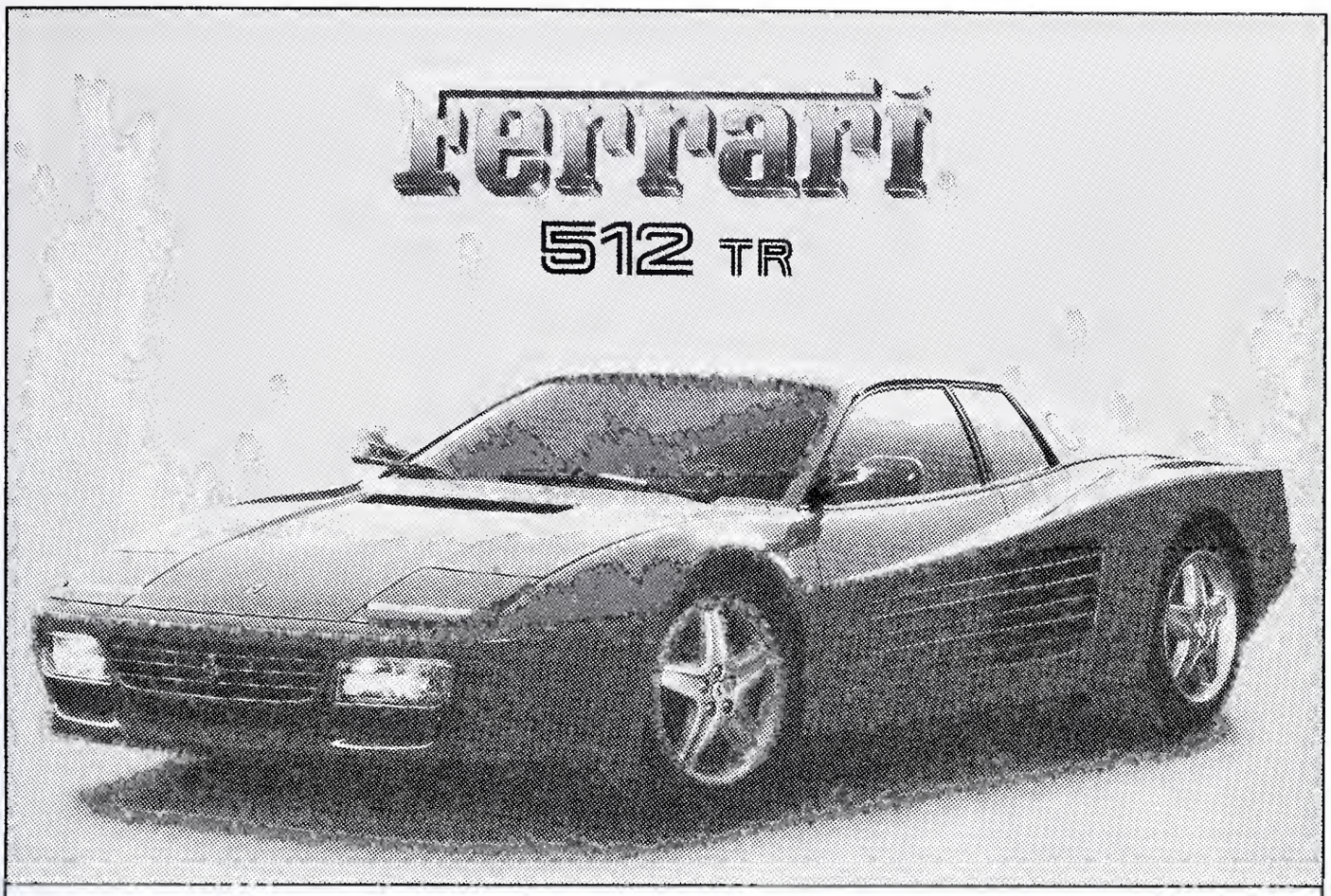

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8/9/80 — PORT ISABEL, TEX: Wind-blown waves crash against the shore as heavy winds produced by Hurricane Allen blow across the Laguna Madre. Roads to South Padre Island became impassable by midmorning. UPI/BETTMANN

STER!

When Catastrophe Strikes

Physicians' Roles in Emergency Planning

BY MARK RICHARDSON
ASSOCIATE EDITOR

The warm waters of the Gulf of Mexico, normally calm, are churning green with whitecaps on this sunny day. Shipping along the normally busy sea lanes running from New Orleans to Veracruz, Mexico, is at a virtual standstill. Waves breaking along Padre and Mustang islands are running 3 to 5 feet above normal and threatening the fragile dunes on the barrier islands. Shrimpers, pleasure boats, and sailing craft are heading for port, while the residents along the shore have begun what promises to be a tense wait for the next few days.

At a point 150 nautical miles due east of Port Aransas, Hurricane Polly is gaining strength in the Gulf. Her 130-mile-per-hour winds have earned her Level Three (very dangerous) status, and the damage and destruction she has brought to several Caribbean islands in the past 72 hours have earned her a reputation as a killer storm.

Along the Texas coast from Galveston to Brownsville, storm watchers are studying the weather radar and the sky for signs of which direction Polly will go. From 23,500 miles in space, the GOES II satellite keeps a constant infrared vigil over the swirling storm, as it has since she began as a tropical depression off the western coast of Africa 2 weeks earlier. And at an Air Force base in Biloxi, Miss, a specially modified C-130 aircraft is taking off on a mission to fly directly into the heart of Polly to measure her intensity, her steering currents, and most importantly, her probable direction.

On the basis of that flight, the National Hurricane Center in Miami issued its latest computerized forecast, putting the highest probability of Polly's landfall in the Corpus Christi area within the next 2 days. It has been 22 years since a

major storm has made a direct hit on that city, and more than half of the population has never been through a hurricane, making the potential of serious injury and loss of life quite high.

Public safety officials, emergency planners, and police have begun martialing forces and studying plans for evacuation and rescue. Meanwhile, hospitals and clinics — both in coastal cities and many miles inland — are canceling leave, vacations, and elective surgeries, and planning either to evacuate patients, if necessary, or to prepare for an influx of post-storm casualties. Disaster plans are located, dusted off, and reviewed by physicians and administrators in advance of the storm.

In Austin, 200 miles from the ocean and some three stories below ground level, the disaster response team of the governor's Division of Emergency Management (DEM) is gathered in its bunkerlike emergency operations center, monitoring the situation.

But they are not very worried; this is the tenth time Polly has struck Corpus Christi, and it probably won't be the last.

"This is only a test . . ."

As you may have guessed by now, Hurricane Polly isn't really out there boiling up the waters of the Gulf and bearing down on the quarter-million inhabitants of the Corpus Christi area. But she has repeatedly "ravaged" all the major cities along the Texas coast for the last decade or so as a standard test of the state's emergency response system to a disaster.

"This is a drill," says a Department of Public Safety trooper over the telephone to the sheriff's office in Nueces County before he begins discussing mock plans to evacuate low-lying areas ahead of the storm.

The officer is one of about two dozen state officials gathered in the DEM operations center for a hurricane exercise, one of an annual series of disaster drills staged each spring to make sure that the system and all its components, human and otherwise, work when called upon.

8/3/85 — GRAPEVINE, TEX: Paramedics and other emergency personnel tend to both the dead and the wounded at the Dallas-Fort Worth International Airport after Delta Flight 191, a Lockheed L-1011, crashed short of the runway. FORT WORTH STAR-TELEGRAM

While a major hurricane is the most likely scenario in which the state's disaster response system would be activated, the DEM also prepares for a multitude of other possibilities, such as a nuclear power plant mishap, a plane crash, an earthquake, chemical spills, terrorist attacks, tornadoes, floods, and even war.

One of the most critical components of the government's response to a disaster of any kind is the role physicians and the state's health-care system play in treating the injured. Most physicians would respond as a part of their hospital's disaster plan, though others might be a part of a Red Cross or other volunteer organization's response.

The first line of defense in the state's disaster plan, according to Jo Schweikhard Moss, an information specialist with the DEM, is each city.

"The elected head of an incorporated area, or an individual they designate, is considered the emergency director for that city," she said. "They are in charge of developing and maintaining a plan of action for their town or city should a disaster occur."

The next line is the county, followed by the state's six designated regional disaster districts, the state DEM, and the federal government. Though several federal agencies are often involved in disaster planning, aid, and recovery, the Federal Emergency Management Administration (FEMA) is the primary agency. In cases of massive disasters with a large volume of casualties, the National Disaster Medical System (NDMS) would be activated. (See sidebar, facing page.)

"Local planners are given instructions in developing contingency plans for disaster that involve various agencies in their city or county. Each agency must sign off on the plan so that when the time comes to implement it, everyone knows their role," said Ms Schweikhard Moss.

Where physicians fit in

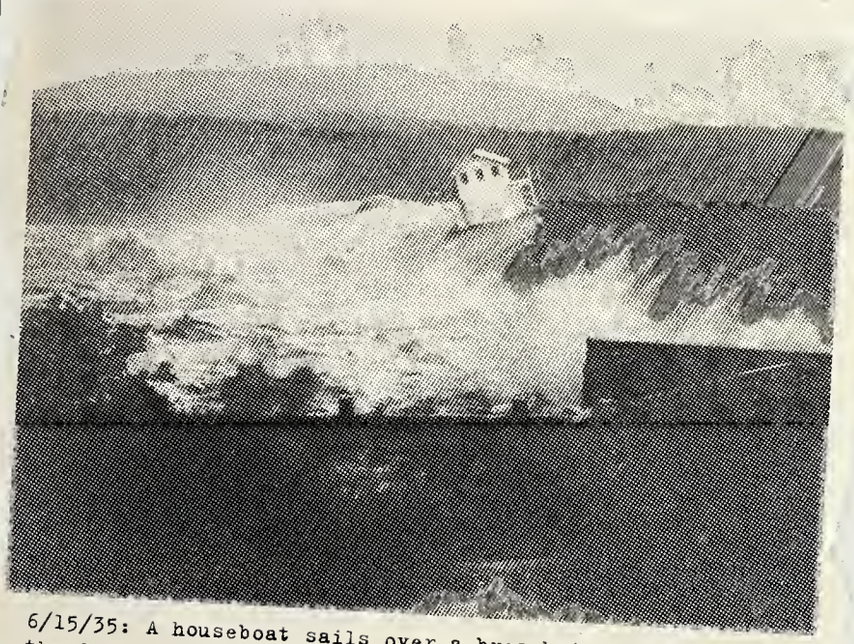
The local level is where physicians and the health-care system are most likely to be involved following a disaster, according to Joe Stone, administrator for the Disaster Response Program of the Texas Department of Health.

"Most local and county plans involve doctors and hospitals. Each hospital is usually asked to develop,

National Disaster Medical System readies for mass casualties

Despite extensive planning for emergency preparedness by state and federal officials, local and regional medical services are able to handle the casualties in the large majority of disasters. But in mass casualty situations, such as are possible when hurricanes or earthquakes strike densely populated areas, the federal government's system of medical "SWAT teams" comes into play.

The National Disaster Medical System (NDMS) was created in 1984 to supplement state and local resources during a peacetime natural disaster and provide backup medical support to the military medical care system during a national security emergency. It is a joint project of the Federal Emergency Management Agency (FEMA), the Department of Veterans Affairs (VA), the Department of Health and Human Services (HHS), and the Department of Defense (DoD).



6/15/35: A houseboat sails over a breach in Austin Dam along the Colorado River in the midst of a massive flood. The site of this photo is now Tom Miller Dam on Lake Austin. AUSTIN HISTORY CENTER, AUSTIN PUBLIC LIBRARY. PHOTO ID #C08484.

According to Robert Elliott, director of emergency medical preparedness for the VA, the NDMS is composed of three parts: a medical response team, a transportation unit, and a system of participating hospitals.

"The program was designed to provide assistance to a disaster area in the form of medical assistance teams, supplies, and equipment," he said. "The NDMS also evacuates patients who cannot be treated at the scene to an appropriate medical facility elsewhere around the nation and provides hospitalization in a nationwide network of hospitals that have agreed to accept patients in the event of a national emergency."

Mr Elliott said the secretary of HHS, which houses the US Public Health Service, is the individual who would order a mobilization of the NDMS.

The basic unit of the NDMS is the Disaster Medical Assistance Team (DMAT), which is composed of a minimum of 29 medical personnel, including at least two physicians, several nurses and EMTs, administrative staff, and other technicians and litter-bearers. The DMAT is designed to be mobile on 6-hours notice, to be self-sufficient for up to 72 hours, and to operate an 80-bed patient-holding facility around the clock at the team's home airport or at the disaster site. Other NDMS sites are considered receiving units, hospitals around the country on standby to receive casualties. There are currently about 1,500 hospitals designated as receiving units, and about 30 DMATs are organized or in the process of being formed.

A DMAT may be sponsored by a major medical center, public health agency, or a voluntary agency such as the Red Cross. The sponsor provides training, storage facilities, basic response kits, and a center for team organization.

According to Samuel Burkette of San Antonio, the Texas-area manager for the NDMS program, NDMS receiving units are based in Houston, Dallas, San Antonio, and Austin, with DMATs stationed in El Paso and Houston and efforts under way to form other DMAT units in San Antonio and Dallas.

He said an earthquake is the most likely situation in which the NDMS would mobilize.

"We figure that with the type of earthquake that came around in 1812 or 1813 in the New Madrid fault in southeastern Missouri, you are going to see 3,000 to 4,000 fatalities and 200,000 to 300,000 injuries," he said. "Once the states in this area determine that they are going to be overwhelmed with the magnitude of the casualties, they ask for federal assistance and the NDMS is activated."

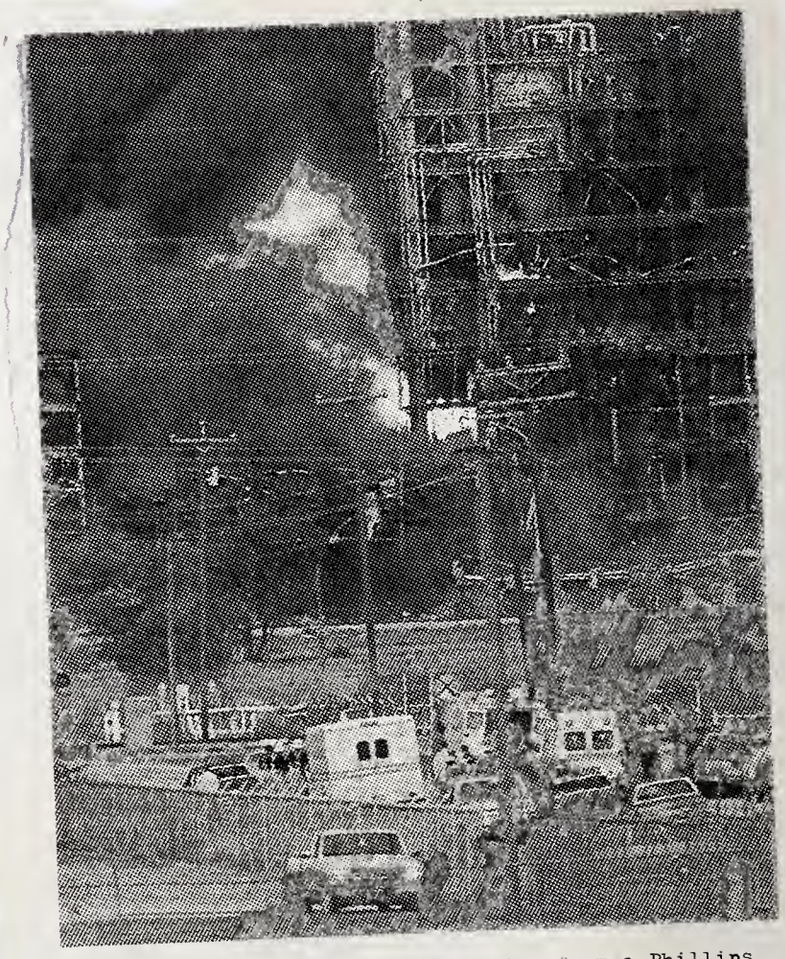
He said the process of activating the system can take between 48 and 72 hours from the time of the disaster, but that once mobilized, members of a DMAT team become employees of the Public Health Service, on the federal payroll, which allows the physicians to practice medicine anywhere in the country.

The physicians who serve in the NDMS come from all specialties, according to Mr Burkette.

"We seek a broad range of physician volunteers, because we expect to see a wide range of casualties," he said. "We need trauma physicians, but we also need orthopedists, surgeons, and even psychiatrists, for those who have lost entire families or loved ones."

For more information about the NDMS or about volunteering to serve in a DMAT, contact Robert F. Elliott, director of emergency medical preparedness, Veterans Affairs Medical Center, Building 203-B, Martinsburg, WV 25401.

12/4/78 — STRATFORD, TEX: A tornado dips from a storm cloud just west of this town in the Texas Panhandle, sending the local population scrambling for cover. UPI/BETTMANN



10/23/89 — PASADENA, TEX: Flames rise from a Phillips Petroleum plastics plant on the Houston Ship Channel that was hit by a series of deadly explosions. UPI/BETTMANN

in coordination with the local disaster plan, a plan of action to put into effect when an emergency is declared," he said. Such a plan usually involves making sure sufficient medical staff and supplies are available, that items such as emergency generators are in working order, and that lines of communication with local officials are established and kept open during the crisis.

"The health-care system is often called upon after the crisis has passed to assist with immunizations and counseling and assistance for survivors," Mr Stone said.

Corina Love, director of emergency services for the city of Corpus Christi, said hospitals are an integral part of any local disaster plan.

"Most hospitals run an emergency drill at least once every 2 years, so most physicians are familiar with procedures such as triage. In fact, we are making plans to have a mass casualty exercise in a few weeks," she said. "The scenario will involve an airplane crash, and we will involve the majority of major hospitals here in town."

Such drills involve all phases of the local health-care system from the emergency medical services to trauma centers and the social services system as well, she said.

Ms Love said that in addition to governmental entities, private agencies also are involved in responding to disasters. Agencies such as the American Red Cross, the Salvation Army, power companies, the phone company, and others play a role in assisting after a crisis, she said.

Corpus Christi is prepared to deal with, in addition to a hurricane, air crashes, massive oil spills, an explosion at a refinery or grain elevator, or a chemical spill along a highway or railway.

"We deal with major disasters," she said. "Particularly if there were a situation that we would need to evacuate some areas and shelter those people, then we would respond."

The state's disaster plan

The next level in the process in the state's DEM system is the six disaster districts (see map, p 45), which serve as a support mechanism for cities and counties. Each district has a regional liaison officer (RLO) who links the state headquarters in Austin and communities in the district.

Abel Contreras is the RLO for District 3, which encompasses most of South Texas, including the San Antonio, Corpus Christi, and Rio Grande Valley areas. His district is subdivided into three smaller divisions.

"My job is to support the efforts of local officials in a disaster and to serve as a liaison between them and the state when state assistance becomes necessary," he said. "Communities are required to exhaust local

Physicians are the backbone of an emergency response

Physicians have always been the backbone of any response to a disaster. Whether it is a natural disaster or a man-made catastrophe, there are wounds to bind, and physicians often are called on to perform their duties under extreme circumstances.

Through the years, Texas has experienced more than its share of disasters, from the 1900 hurricane that killed more than 6,000 in Galveston to a mass shooting in Killeen in 1991, killing 23 and traumatizing an entire city.

Physicians trained to deal with mass-casualty disasters say that when a tragedy strikes, planning, patience, and clear thinking will help a doctor respond to the situation. And with each disaster, physicians are learning more about how best to respond.

According to F. David Prentice, MD, Houston, chairman of TMA's Committee on Emergency Medical Services and Trauma, the best way for a physician to respond when a disaster strikes is to report to the hospital and follow the local disaster plan.

"Each county or city is going to have a local emergency preparedness committee, which will develop an area-wide disaster program that will be far broader than the medical community," he said. "But the medical community needs to be involved in each community's emergency preparedness planning process."

He added that once the planning process is completed, each element of the plan should do its job.

"Physicians need to understand that when a disaster happens, the place they do not need to be involved in is at the scene," Dr Prentice said. "Anytime a physician hears that a disaster has come down, the prime directive needs to be to go to his or her hospital and prepare to receive people."

There are people, such as emergency medical technicians and others, who are trained to deal with what is happening at the scene, and physicians, as a rule, are not, he said.

James Atkins, MD, Dallas, is the medical director of the Dallas County EMS and as such has been in charge of disaster relief at two major airline crashes at the Dallas-Fort Worth International Airport in the past 4 years. He echoes Dr Prentice's advice that a physician can best respond to a disaster at the hospital.

"What you find out is that a physician is out of his element and a paramedic is in his element," he said. "When we had paramedics at DFW at both of our plane crashes, there was nothing that a physician on the scene did or a decision a physician made that was any different from what a paramedic did.

"The only thing was that they (physicians) slowed down transport by 20 to 30 minutes because they had to reexamine what the paramedic had already examined. And in no case did they change what a paramedic had done," Dr Atkins said.

"One thing I have found is that you should do everything as close to normal as you possibly can in a disaster. Special procedures don't work because you're in such a high-stress situation. People are trained to do their normal job and do it well. Stick to your established routine."

He added that the one exception to that rule might be in a rural area where there may not be as many EMS personnel available, and doctors and nurses could fill in that role.

"Doctors, even in rural areas, should still go to the hospital and have the emergency situation coordinated from there," he said. "If physicians are out at a scene doing search and rescue, they can't be where they are needed to treat patients."

Dr Atkins said the planning process is extremely important to the success of a disaster response.

"Physicians should become intimately involved in disaster planning," he said. "There are many things from a physician's point of view that the emergency planning system needs to coordinate that EMS may have never thought about. They need a physician's input for that."

He said that each major disaster provides emergency planners with knowledge that will help them the next time out.

"When the Delta L-1011 went down, we put into action a plan to control access to the hospital, but we never considered our blood bank across the street," he said. "It turned out that 3,000 people showed up in a short time to give blood, created a hell of a traffic jam, and our ambulances couldn't get through. We had never thought about crowd control at the blood bank."

Dr Atkins gave one final bit of advice for physicians dealing with disasters.

"One thing I have found is that you should do everything as close to normal as you possibly can in a disaster," he said. "Special procedures don't work because you're in such a high-stress situation. People are trained to do their normal job and do it well. Stick to your established routine."

Physicians who wish to become involved in disaster preparedness planning should contact their local city or county office of emergency planning or their local police and fire officials. If unsure who to contact, call the Texas Department of Health's Bureau of Emergency Management for a local contact number.

Post-disaster psychological counseling comes of age

For decades, disaster planners have put a great deal of time and effort into strategies to save lives and treat the injured in a disaster. But in recent years, they have also begun focusing on healing the psychological and emotional wounds left by a tragedy.

While it can take a few weeks or months after a disaster to heal wounds and rebuild destroyed property, emergency planning officials and the medical community have begun to recognize that without some form of intervention, it can take years to heal the emotional scars of the survivors who have lost loved ones, homes, and possessions, and the rescuers who have dealt firsthand with the carnage.

According to Ed Schaefer, head of public information for the Governor's Division of Emergency Management (DEM), while state officials had been discussing some form of organized crisis counseling initiative, it was the reality of a mass shooting in Killeen in October 1991 that pushed them into action. A lone gunman drove a truck through the front window of a cafeteria, pulled out two guns, and began systematically executing the patrons, killing 23 and wounding 33 others in the largest single-day mass murder in American history.

"The toll of his actions wasn't limited to the dead and injured," Mr Schaefer said. "He victimized an entire community."

The Killeen area was fortunate, Mr Schaefer said, that local officials had just a few months earlier geared up for the possibility of mass casualties from Operation Desert Storm, giving the city an unusually large pool of trained personnel to attend to persons overwhelmed by shock and grief at the incident.

Several state agencies also went to Killeen to assist in the process, and from that response began an interagency task force to organize a post-disaster counseling program. Representatives of the DEM, the Texas Department of Health Bureau of Emergency Management (TDH/BEM), the Governor's Crime Victims' Clearinghouse, the Department of Public Safety (DPS), and the Texas Department of Mental Health and Mental Retardation (MHMR) have begun a series of meetings to formulate a program.

TDH already has a program in place to deal specifically with the post-disaster problems faced by EMS and medical personnel, police, and firefighters. The Texas Critical Incident Stress Debriefing Team program is headed by Paul Tabor, who said the goal is to have regional teams available to mobilize and move into an area as soon as possible after a disaster.

"We try to have at least one mental health professional on each of the teams," he said. "Our goal is to assist local officials in their efforts to help their people."

Mr Tabor said the TDH program is in the process of training regional debriefing teams around the state, but that the program is on line and functioning.

Providing assistance for local officials is also the goal of the state's crisis mental health program, according to Mr Schaefer.

"The key to our success is based on the fact that every community has an existing pool of professionals – physicians, counselors, victim services personnel, and clergy – who will undoubtedly provide assistance during any significant event," he said. "Our job will be to train these people in advance of a disaster and then coordinate their efforts during a time of crisis."

The state is using a training program developed by the National Organization for Victim Assistance (NOVA) in Washington, DC. According to Cheryl Triska, victim services coordinator for NOVA, local physicians play a major role in the post-disaster counseling program.

"Physicians can help mitigate a lot of the emotional and psychological trauma disaster victims feel. We work with physicians on how to make better death notifications to minimize the damage."

"Physicians can help mitigate a lot of the emotional and psychological trauma disaster victims feel," she said. "We work with physicians on how to make better death notifications to minimize the damage. Doctors can also be very aware as they treat victims and their families of individuals who may need counseling; that is a very important role they can play."

According to Mr Schaefer, the state is working rapidly to get its program in place and hopes to have much of it done by late this year or early 1993.

"We want it ready to go yesterday," he said. "It's not a matter of if there is going to be another disaster, but a matter of when. We need to be ready when that time comes."

resources before turning to the state for assistance."

While small municipalities depend on elected officials and volunteers to carry out emergency plans, most medium- and large-sized cities, as well as urban counties around the state, hire staff specifically to develop and implement such plans, he said. Consequentially, much of his effort is focused on helping smaller towns and rural counties in the disaster planning process.

At the state level, the DEM maintains offices in the Texas Department of Safety complex in Austin and spends much of its time devising and modifying plans for various emergency scenarios around the state.

According to Ms Schweikhard Moss, every state agency is included in the DEM's standard operating procedures in an emergency. While agencies like the Department of Public Safety (DPS) and Texas Department of Health (TDH) play a major role in any disaster relief effort, oth-

er agencies, such as the Railroad Commission, General Land Office, and the Parks and Wildlife Department are given specific duties. Other agencies like Banking, Commerce, and the Insurance Board are routinely involved. And, of course, the Comptroller's office is included in the plan to make sure the state's taxes don't go uncollected.

When a crisis occurs or when conditions such as a hurricane, flood, or severe weather could cause a disaster, the DEM activates its emergency operations center. The center is located in a large room three stories below ground level at the DPS headquarters and is "self-contained" to be able to operate for long periods of time without outside assistance.

The center is connected to the outside world by a communications system consisting of dozens of telephones, computers, and facsimile machines. Maps of various regions cover the walls, as well as "situation boards" where the status of requests filtering in from the disaster site are displayed for everyone working in the center. Large television monitors display the various weather radar sites around the state and can be tuned in to monitor news broadcasts.

At a table in the center of the room are the EOC coordinator and several assistants. Around three sides of the room sit representatives from state agencies to assist if their areas are called upon.

"The role of the EOC is to coordinate the resources of the state in a disaster and assist communities at the disaster site as a resource," said Ms Schweikhard Moss. "We also serve as a liaison between the state and the federal government, calling on them if additional help is needed."

Planning for the unplannable

While some disasters, like hurricanes, may give emergency personnel a short lead time to prepare, most happen with little or no warning. Plane crashes, earthquakes, explosions, and other crises can command the maximum response from an emergency management program on extremely short notice, so those who are charged with preparing for those eventualities spend a great deal of time planning.

"We have developed extensive operations manuals involving each agency, so when the time comes to act everyone knows what their role will be," said Ms Schweikhard Moss.

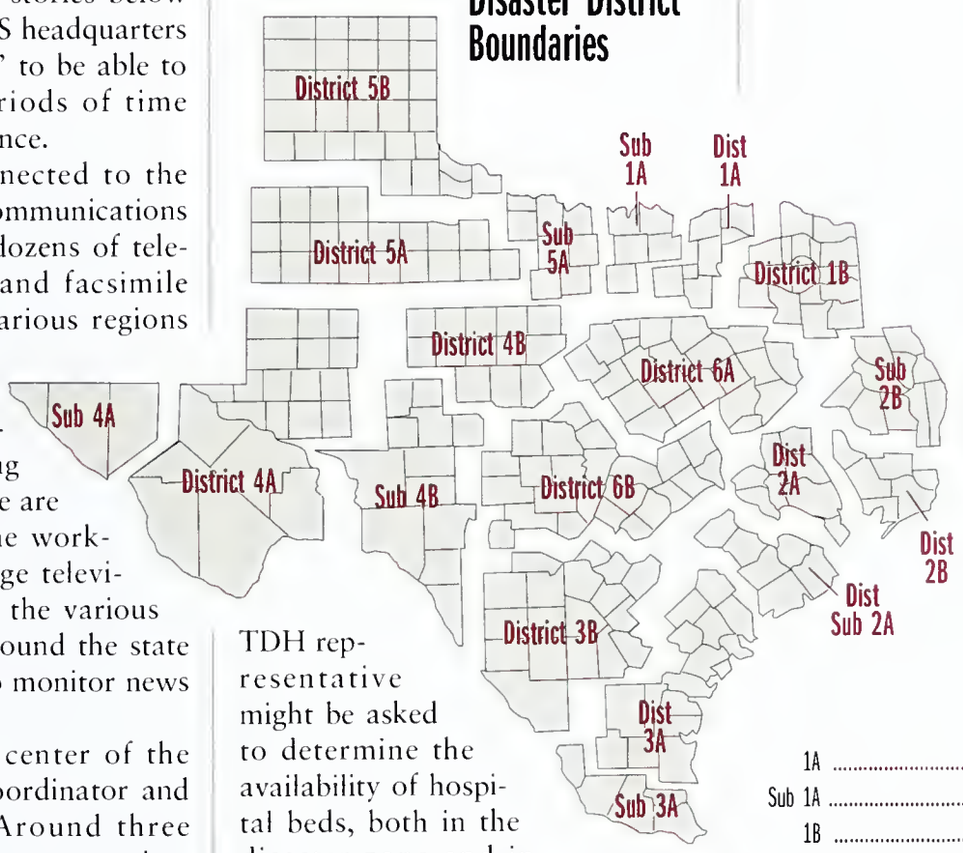
For instance, using the example of a major hurricane on the coast, the TDH representative might be asked to determine the availability of hospital beds, both in the disaster zone and in possible evacuation areas, and might also check on the supplies at various pharmacies in the area so that prescriptions could be filled for those evacuating.

The Public Utility Commission representative might be charged with coordinating steps to restore electric, gas, and telephone service in affected areas.

Most hospitals have developed disaster plans that they are required to test on a regular basis. Many participate in drills, sponsored by their city or county emergency planning office, of plane crash or other disaster scenarios that might produce mass casualties. The tests check on EMS response, trauma center procedures, and post-disaster events, such as evacuations, counseling, and property protection.

"We have to be ready for most anything," said TDH's Joe Stone. "We don't have to use the system very often, but when we need it, it has to work." ★

Disaster District Boundaries



1A	Dallas
Sub 1A	Fort Worth
1B	Tyler
2A	Houston
Sub 2A	Pierce
2B	Beaumont
Sub 2B	Lufkin
3A	Corpus Christi
Sub 3A	Harlingen
3B	San Antonio
4A	Midland
Sub 4A	El Paso
4B	Abilene
Sub 4B	San Angelo
5A	Lubbock
Sub 5A	Wichita Falls
5B	Amarillo
6A	Waco
6B	Austin

Science and Education

Lack of donated brain tissue slows neurological disease research

THOUGH MUCH PROGRESS has been made in the past decade in the field of organs donated for transplantation, physicians and researchers say there is a critical shortage of brain tissue available for research.

Shelley Ann Sekula, MD, Clear Lake City, said several national brain banks are reporting extremely few donations and added that the lack of donor brains is holding up vital research in the areas of Alzheimer's, Tourette's syndrome, Parkinson's, and other neurological diseases.

Dr Sekula, a dermatologist, is the national chairman of the Brain Bank Committee for the Tourette's Syndrome Association. She said many physicians are unaware of the need for donations of both brain tissue from persons with neurological disease and those of healthy individuals.

"We can do MRIs, CT scans, and PET scans until the cows come home, but we're really not getting at the tissue that has the problem," she said. "Physicians are often not really aware that if we don't get the tissues to the researchers for study, the research goes nowhere."

Dr Sekula said she became personally involved in the fight against Tourette's syndrome when her son was diagnosed with the disease 3 years ago. But she said the problem of a lack of postmortem brain donations affects research into a wide range of neurological diseases. She said patients, their families, and their physicians need to be educated about the need for brain tissue to assist in research for Alzheimer's disease, Tourette's syndrome, depression, schizophrenia, Huntington's and Parkinson's diseases, and others.

According to Edward D. Bird, MD, professor of neuropathology at Harvard Medical School, an increasing number of researchers are studying postmortem brain tissue and more tissue is needed to ensure continued progress.

"It is important to stress, time and again, that not one of the studies could have taken place without the concern and generosity of those who donate brain tissue," he said. "Animals do not get schizophrenia or Huntington's disease or any of a number of other brain disorders — only human beings do. That is why only the study of human brain tissue will provide the answers so many are searching for."

Dr Sekula said that while most of society today understands and agrees with the concept of taking organs after death for transplant, there is still a taboo about removing the brain.

"When it comes to brain tissue, it's often like walking into the year 1000," she said. "There is a lot of mystery, there is a lot of misunderstanding, there is a great deal of apprehension on the part of even professionals about the sanctity of that particular tissue." She said some people fear the loss of their souls, that they might be violating something precious that they might not be violating if they take a cornea or a kidney. She added that a calm, understanding approach to family members can ease their fears about donating brain tissue.

"It's a lost value," she said. "People (with these diseases) are dying and being buried and taking their wonderful clues with them."

She said the shortage of available tissue cannot be overemphasized. Citing the example of donations for Tourette's syndrome, she said as many as 1 million people may have the disease in the United States, but only 14 brains have been donated specifically for Tourette's disease research in the last 12 years. The numbers are higher for Alzheimer's research due to a push initiated by family members, but other neurological diseases are faring even more poorly than Tourette's.

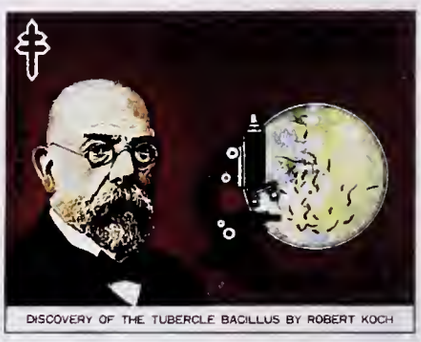
Dr Sekula said several brain bank facilities exist around the country, including small facilities at Baylor College of Medicine in Houston and The University of Texas Southwestern Medical School in Dallas. Other major facilities are housed in Miami, Los Angeles, and suburban Boston, all of which are mainly storage facilities for donated tissue.

Physicians seeking information on brain donations may contact any brain bank or can call 1-800-BRAINBANK (800-272-4622).

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

Stamp exhibit chronicles fight against tuberculosis

THE HISTORY OF THE BATTLE against tuberculosis (TB) is uniquely chronicled in the thousands of colorful stamps printed



A 1982 stamp from Sri Lanka commemorates the discovery of the tuberculosis bacilli by German researcher Robert Koch in 1882.

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

New cancer research facility established in Temple

Texas A&M University College of Medicine, Temple — A new cancer research facility has been established at the Olin E. Teague Veterans Center Campus of Texas A&M College of Medicine. John J. Reinhart, MD, professor in the department of internal medicine at Texas A&M, will serve as director of the laboratory, which will evaluate interleukins and colony-stimulating factors as agents to reverse or prevent bone marrow damage resulting from high-dose chemotherapy. Researchers also will study autologous peripheral blood stem cell transplantation.

Scientists identify genes responsible for drug effects

Baylor College of Medicine, Houston — Scientists have identified the genes responsible for how anesthetics affect the body, a discovery that could lead to safer surgery. According to Glenn Kirsch, MD, associate professor of anesthesiology, the finding may lead to safer and more effective anesthetic drugs and may avoid the risks and side-effects associated with those currently in use. The research team identified genes in rat brains that encode five types of ion channels responsible for brain impulses. Kirsch and his colleagues found receptor sites where drugs "stick" to certain ion channels, giving clues to the brain's response to anesthetics and many nerve drugs. Dr Kirsch said the information could be useful in developing anesthetics that could isolate specific parts of the body.

Scientists accelerate natural process of wound healing

The University of Texas Medical Branch, Galveston — A recently developed biochemical appears to speed up wound healing by as much as 80%, according to researchers here. The biochemical, thrombin receptor-activating peptide-508 (TRAP-508), has accelerated the healing process by at least 4 days in rodent model wounds with a single application of the substance, according to Darrell H. Carney, PhD, leader of the research group. Such an agent might help heal difficult wounds and sores, such as severe burns and persistent sores among diabetics, and could significantly shorten the time required for removal of sutures and recovery from surgery. TRAP-508 is a synthetic reproduction of a small segment of the enzyme thrombin, released by the body as a reaction to injury. The research was published in the May *Journal of Clinical Investigation*. Researchers are now seeking FDA approval for clinical testing.

New cancer drug shows strong early results

The University of Texas Health Science Center, San Antonio — Taxotere, a drug made from the needles of the European yew tree, has helped dozens of cancer patients with little hope of otherwise beating their advanced tumors. Early clinical results in 43 patients have been so promising that researchers at UT, the Cancer Therapy and Research Center (CTRC), and Brooke Army Medical Center are entering the second phase of testing. Taxotere may be submitted for federal approval within a year. Daniel Van Hoff, MD, research director at the CTRC, said that unlike its more well-known cousin taxol, taxotere is in virtually unlimited supply and is taken from the needles of the European yew, not the bark of the endangered Pacific yew tree. The Phase I trial of the drug established the optimal dosage. In the second phase, researchers say they will study taxotere's effect on lung cancer, ovarian cancer, melanoma, and breast cancer.

Information for this column comes from a variety of sources, including academic institutions, state and federal agencies, and private institutions. We welcome submission of items of interest. Send them to Texas Medicine, *Science and Education Editor, 401 W 15th St, Austin, TX 78701.*

A stamp issued in 1897 from the Republic of New South Wales, which later became part of Australia, is believed by collectors to be the earliest edition pertaining to tuberculosis and nursing care.

to raise funds for research and to commemorate breakthroughs in its treatment.

Beginning August 20, the TMA History of Medicine Museum will feature a new exhibit on the history of TB depicted in a portion of a private collection of stamps and memorabilia owned by Kurt Lekisch, MD, MPH, of Austin. Dr Lekisch, an internist, has spent a large part of his career helping in the fight against TB and has traveled to places such as India, Vietnam, and Rhodesia (now Zimbabwe) to work and observe the culture and nature of the devastating disease. During his travels, one of his many hobbies has been to amass a colorful collection of old and new stamps, several volumes of which are directed towards the fight against TB.

"Over the years, I had accumulated, theoretically and practically, a world of interesting things in relation to tuberculosis, so when I started to collect medicine stamps, tuberculosis was one field I thought would be interesting, based on my experiences with this illness," Dr Lekisch said, adding that his TB stamps are only a fraction of his total medical stamp and memorabilia collection, which he has painstakingly mounted and collected in binders. "Only eight of my books pertain to tuberculosis. I have more than 175 volumes of stamps and other items relating to medicine."

He said he collects medical stamps from throughout the world

through dealers, catalogs, other collectors, and correspondents. He said his travels have shown him that stamp collecting is not as popular here as it is in Europe and Japan.

"Unfortunately, in the United States, people would rather collect baseball cards and stuff like that," he said. "In Europe, stamp collecting is the most outstanding hobby of people who have time and money and are interested in developing something to entertain themselves. There are, proportionately, very few stamp collectors in this country."

Items on display include a historical review of the Christmas Seal in the United States. Emily Bissell began selling Christmas Seals in 1907 to raise money for a sanitarium. With the help of a Philadelphia newspaper, she raised more than $3,000. The next year the Red Cross took over the seals and a national effort began. Today, the American Lung Association sponsors the production and distribution of the seals in a continuing effort to battle all lung diseases, including emphysema, asthma, chronic bronchitis, and TB.

The exhibit also records the story of consumptive homes, international efforts in the fight against TB, the Cross of Lorraine (universal symbol of TB), and the heroes in medicine who contributed to the discovery of the TB bacilli, as well as the history of TB in Texas.

The exhibit will be on display in the first floor lobby of the TMA building at 401 W 15th St in Austin until December 31, 1992. Exhibit hours are 8:15 am to 5:15 pm, Monday–Friday and 9 am to 1 pm Saturdays. The building is closed on most holidays. For more information, contact Susan Brock, TMA library director, at (800) 880-1300 or (512) 370-1540. ★

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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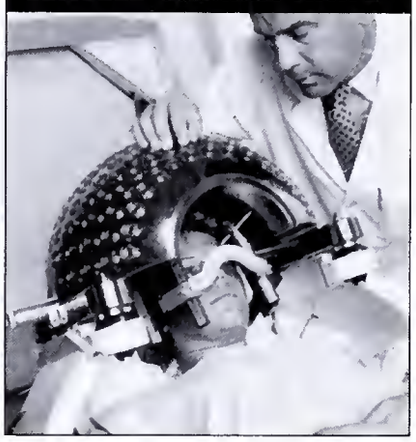

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Law

Fraud alert takes aim at deals between doctors and hospitals

THE SCENARIO IS NOT NEW. A small Texas hospital is minus a surgeon on staff. A vigorous recruitment effort is set in motion by the hospital to bring a surgeon into the community. In an attempt to hire the surgeon, the hospital agrees to pay the physician a 1-year guarantee and to help him or her establish a private practice. But a problem arises. A special fraud alert questioning hospital incentives to physicians is issued by the Office of Inspector General (OIG). Now, the doctor and hospital are leery of the arrangement.

"This is a perfect example of where the fraud alert could ultimately create more problems than it is trying to solve," says Charles Bailey, legal counsel for the Texas Hospital Association. "It is very unfortunate that communities are being deprived of medical treatment because the doctor is worrying about OIG investigations."

The OIG fraud alert issued in May 1992 is aimed at physician-hospital incentive packages that the Department of Health and Human Services (HHS) believes may be in violation of the antikickback provisions of the Medicare and Medicaid Act. Violations carry criminal penalties, or exclusion from participation in the Medicare and Medicaid programs, or both. Hospital recruiting and retention incentives are not protected under HHS' "safe harbor" regulations. There has, however, been some consideration by HHS to grant protection under "safe harbor" for certain hospital incentives for physicians starting a new practice.

"The hospital incentives alert is designed to identify those relationships between physicians and hospitals that the OIG believes provide improper incentives for treatment or referrals," says Texas Medical Association General Counsel Donald P. Wilcox, JD. "We don't want physicians to be blindsided. The OIG is out there watching hospital-doctor relationships and will question incentives to refer or to treat at a particular facility."

The Office of Inspector General's special fraud alert is designed to identify relationships between physicians and hospitals that may provide improper incentives for treatment or referrals.

A broad range of hospital-physician agreements are listed in the alert. The OIG contends that some incentive programs can interfere with the physician's judgment of what is the most appropriate care for a patient; increase costs to the Medicare program; and induce physicians to refer patients to hospitals providing financial incentives rather than to hospitals offering the best or most appropriate care. The following are areas the OIG suggests may have the potential for unlawful activity.

- Payment of any sort of incentive by the hospital each time a physician refers a patient to the hospital.
- The use of free or significantly discounted office space or equipment (in facilities usually located close to the hospital).
- Provision of free or significantly discounted billing, nursing, or other staff services.
- Free training for a physician's office staff in areas such as management techniques, CPT coding, and laboratory techniques.
- Guarantees that provide that if the physician's income fails to reach a predetermined level, the hospital will supplement the remainder up to a certain amount.
- Low-interest or interest-free loans, or loans that may be "forgiven" if a physician refers patients (or some number of patients) to the hospital.
- Payment of the cost of a physician's travel and expenses for conferences.
- Payment for a physician's continuing education courses.
- Coverage on a hospital's group health insurance plans at an inappropriately low cost to the physician.
- Payment for services (which may include consultants at the hospital) that require few, if any, substantive duties by the physician or payment for services in excess of the fair market value of services rendered.

Mr Wilcox suggests physicians review the OIG list and compare any agreements they may have with the hospital with that list. If an arrangement is suspect, then the physician

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

and hospital should determine the appropriateness of the package.

"Some of the items labeled by the OIG as 'incentive arrangements' look pretty innocent, such as the payment for continuing education courses," says Mr Wilcox. "However, we have seen contracts where part of the deal involved the doctor's occupation of facilities at a discounted or no-pay basis if they referred patients to the hospital's laboratory facilities. We have never felt that was appropriate."

Mr Bailey believes the fraud alert is "not balanced" and doesn't "weigh the benefits of recruitment benefits in comparison to benefits provided to the community or the hospital.

"Abusive situations should be reviewed by the OIG," says Mr Bailey. "Certainly no contract should have any tie to referrals of business to the hospital or admissions agreements. Unfortunately, there probably have been some agreements like that."

Complaints to the OIG will probably result when it appears one hospital is losing patients to another facility or a physician believes a colleague is receiving an undeserved favorable incentive package.

"Anytime there is payment based on volume or cost of service the OIG will have a high interest in the arrangement," says Mr Wilcox. "This is what the OIG is trying to identify under the theory that it is an improper incentive and encourages more services than are really necessary."

Legal articles in Texas Medicine *are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.*

Understanding "what ifs" of potential liabilities

Hugh M. Barton, JD
TMA Assistant General Counsel

Physicians are generally aware of their potential liability when treating an established patient. However, physicians are often involved with people who are not generally considered their patients or with patients they have not treated for a considerable time.

Q: If I see a patient at the request of the patient's employer or worker's compensation carrier to render a second opinion, am I potentially liable for malpractice?

A: Probably not. In *Henkemeyer v Boxall* (1), an injured employee was examined by a physician at the insistence of the employer and its worker's compensation carrier. The physician examined the employee's spine, shoulder, and hip. After reviewing the employee's medical history, the physician concluded that the employee's orthopedic problems were not exacerbated by an accident while driving a truck 20 months earlier. The physician was not retained to provide medical treatment by the employee, the employer, or the insurance carrier.

Three days later the employee died of an acutely expanding abdominal aortic aneurysm.

The employee's estate sued the physician for malpractice, claiming that the physician failed to find an aneurysm on x-ray and that this failure breached the physician's duty to exercise the required skill and care.

The appeals court held that in the absence of a physician-patient relationship, the physician's only duty was to not harm the patient during the examination and that there was no allegation to this effect. The court held that the physician could only be held liable for malpractice where a physician-patient relationship existed; the court found no evidence of this in the case where the physician contracted with the insurance carrier and was not retained to provide treatment and care.

Q: What about preemployment physicals? What's my liability there?

A: Where no physician-patient relationship is formed, there can be no liability for medical malpractice. In *Felton v Schaeffer* (2), a physician performed a single medical examination as part of a preemployment screening process. The "patient" had been told not to eat or drink prior to the examination and concluded that he was not supposed to take his blood pressure medication. As a result, he had an elevated blood pressure during the examination. The physician assumed that the prospective worker had not complied with his prescribed medication regimen, had uncontrolled high blood pressure, and reported that the person was unsuitable for employment.

The applicant sued for negligence and medical malpractice. The physician defended on the grounds that no physician-patient relationship existed; thus he could not have been negligent. On appeal, the court held that because the plaintiff didn't visit the physician for treatment or advice and did not rely on any advice given by the physician to his detriment, there was no physician-patient relationship created. Thus, any misdiagnosis of a medical condition during an examination was not actionable as negligence or medical malpractice.

A similar holding occurred where the physician was hired only to re-

view an applicant's medical records for employment fitness, and the physician never examined the patient. The physician concluded that the applicant suffered from a personality disorder, and the applicant was not hired. After learning of the report from the physician, the applicant sued. The appeals court held that the defendant physician's review of medical records for a third-party employer did not support a professional relationship between doctor and patient sufficient to support a malpractice action (3).

Q: If somebody comes to my office wanting to be seen as a patient, but I decline to see him or her, can I be held liable if his or her medical condition worsens?

A: Again, as long as no physician-patient relationship exists, there can be no medical malpractice. In *Salas v Gamboa* (4), the father of a sick newborn took his child to a pediatrician's office after having been refused treatment at a hospital. What was said there about an emergency was unclear, but the physician declined to see the child nor did he talk with the father. The child was taken to a nearby hospital but died 5 days later. The parents later sued for wrongful death.

In his motion for summary judgment, the defendant physician argued that he never had a physician-patient relationship with the family or child, that he had never met or agreed to treat them, that he never billed them for any medical services, and that his office was not an emergency room. The father's affidavit failed to controvert the lack of a physician-patient relationship.

On appeal, the court stated that physicians may not be held liable for refusing to respond to the call of a person, even though they are in urgent need of medical help, if no physician-patient relationship exists at the time the call is made or at the time the person presents for treatment.

Q: What if this situation occurs in a hospital? Does the result change?

A: In *Fought v Solce* (5), an orthopedic surgeon was "on-call" to a hospital emergency room. When he was consulted by the emergency room physician about a patient injured in a motorcycle accident, he declined to come to the hospital and examine the patient. The patient was transferred several times and eventually his leg was amputated. The issue in the case was whether the orthopedic surgeon had a duty to render care to the plaintiff and whether the duty was breached.

It was never disputed that no physician-patient relationship existed between the parties. The court held that the defendant physician had no duty to render care to the plaintiff because (a) he had no contractual obligation to the hospital to be "on-call," and (b) he was not required to be "on-call" to retain his hospital privileges. Thus, his volunteer on-call status did not impose any duty to the patient.

The court noted that Texas law may impose criminal penalties where hospitals and hospital staff refuse to render emergency care. But, the court refused to find a civil cause of action in that law that would render the defendant liable.

It should be noted, however, that the facts in this case occurred in 1984, before the passage of more stringent federal "anti-dumping" laws. As that law now stands, an "on-call" physician who refuses to render treatment may be subject to administrative sanctions and fines, although there is still no private cause of action against the "on-call" physician.

Q: What's my liability if one of my patients fails to return for treatment?

A: In *Knapp v Eppright* (6), a patient who underwent a leg-lengthening procedure brought a medical malpractice action against the physician who performed the procedure, alleging that complications caused the patient's leg to "bow" and that the screws holding the plate in her leg broke. In upholding summary judgment in favor of the defendant physician, the appeals court noted that if the patient terminates the physician-patient relationship by voluntarily choosing not to return to her physician, there can be no abandonment and thus no malpractice.

Q: How long do I remain liable after the last time I see a patient?

A: The statute of limitations issue is litigated often with varying results. At press time, the latest opinion from the Texas Supreme Court is *Rowntree v Hunsucker*, No. D-1665 (opinion delivered May 27, 1992).

In that case, the plaintiff saw the defendant physician in 1985 for hypertension; the physician prescribed Sectral. Her last office visit was in September 1986, at which time she was continued on Sectral. She called in May 1987 requesting a refill for Sectral but did not express any complaints; she did not receive any medical advice at the time. The defendant physician prescribed Sectral with five refills. The plaintiff suffered a stroke in January 1988 and filed suit in 1989 alleging failure to diagnose the injury-causing condition.

The issue on appeal was whether the plaintiffs filed their suit within the statute of limitations. The court of appeals held that the statute of limitations was extended by the pa-

tient's taking of medication. The Supreme Court disagreed, finding that the refilling of her Sectral prescription did not "demonstrate sufficient involvement by the physician to constitute a continuing course of treatment" that would extend the statute of limitations. The Supreme Court noted that extending limitations until all authorized prescriptions had been obtained would encourage physicians not to authorize refills and to insist upon an office visit for each prescription, thus increasing the cost of medical care.

Q: How about a situation where the patient refuses to comply despite repeated efforts to reach them?

A: *In Payton v Weaver* (7), a nephrologist was charged with abandoning a dialysis patient. The patient and her nephrologist had had previous litigation that was settled with a court order that the nephrologist treat her if she kept all appointments, observed her prescribed diet, abstained from use of alcohol or drugs, and sought regular counseling.

After a year, the nephrologist discharged her for failing to live up to the terms of the agreement and gave her a list of dialysis clinics in the area. She sued the nephrologist and two hospitals for abandonment.

The trial court held that there was no abandonment since the nephrologist gave sufficient notice of termination and ample time to find another physician. The hospitals were not ordered to continue treatment, since the court reasoned that a chronic need for medical treatment does not constitute a need for emergency care, even if the treatment is life-sustaining.

On the other hand, a similar fact situation in Mississippi produced a somewhat different result. In *Brown v Bower* (8), a hospital was ordered to continue dialyzing a seriously noncompliant patient as part of its Hill-Burton Act obligation. However, the nephrologist was not required to participate in that care since the Hill-Burton Act provided no authority for the court to compel treatment by an individual.

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Propylhexedrine removed from controlled substances act

PROPYLHEXEDRINE HAS BEEN deleted from Schedule V of the Texas Controlled Substances Act, according to the Texas Department of Health.

The final rule, which removes the substance from the Schedules of the Federal Controlled Substances Act, was issued by the Drug Enforcement Administration. Propylhexedrine was placed in Schedule V of the Federal Controlled Substances Act in April 1988 to conform with international control of the drug under the 1971 Convention on Psychotropic Substances. The United States was notified on June 10, 1991, that the substance had been decontrolled internationally.

Section 481.036 Schedule V of the Texas Controlled Substances Act was amended to delete the substance. A current schedule can be obtained from the TDH Division of Food and Drugs at (512) 458-7248. ★

OSHA UPDATE

The deadlines for compliance with the OSHA Bloodborne Pathogens standard have come and gone. However, physicians are reminded they do face the OSHA regulation on a daily basis and should stay alert to the standard. In-depth articles that appeared in Texas Medicine *on the OSHA bloodborne pathogens regulations can be found in the May 1992, June 1992, and July 1992 issues. The following are some of the most common questions received by the Texas Medical Association Office of General Counsel.*

I have a small office with only clerical staff. Do the rules apply to my office?

A review of employee duties is required to determine if they fall under the regulations. If your diligent review reveals there is no opportunity for exposure to blood or other potentially infectious materials as defined by the bloodborne pathogens rules, then this particular rule would not apply to your office. This is not to say your office is not under other OSHA regulations. OSHA regulations concerning safe workplaces and job duties for employees still apply in this case.

What are my duties as an "employer" under the OSHA Bloodborne Pathogens rule when one of my staff experiences an exposure incident?

The rules, specifically 29 CFR Section 1910.1030 (f)(3), require the employer to immediately make available to the exposed employee a confidential evaluation and follow-up. The evaluation and follow-up should contain at least the following elements: (1) documentation of the route(s) of exposure and circum-

stance under which the exposure incident occurred; and (2) identification and documentation of the patient (source individual), unless the employer can establish that identification is not possible or prohibited by state law. The patient's blood, if available, should be tested as soon as feasible in order to determine HBV or HIV infection. If the patient is already known to be HBV- or HIV-infected, testing need not be repeated. OSHA, in Instruction CPL 2-2.44C (m)(6)(c)(2)(a), has interpreted "if available" to mean blood samples previously drawn.

Documentation of efforts should be made in all cases. For example, if the identity of the exposure source is unknown or if the patient refuses consent to a test for HIV or HBV, such facts should be documented.

If one of my employees is exposed, may I test the patient (source individual) for HIV?

The Texas Health and Safety Code, in Section 81.102(a), provides that "a person may not require another person to undergo a medical procedure or test designed to determine or help determine if a person has AIDS or HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS unless . . ." a specific statutory exception exists. Listed in Subsection (a)(4)(D) is the specific exception to "manage accidental exposure to blood or other body fluids, but only if the test is conducted under written infectious disease control protocols adopted by the health care agency or facility." Therefore, part of the exposure control plan should incorporate an infection control plan that also would be in conformity with Subsection (c) of Section 81.102 of the Texas Health and Safety Code, which provides that:

> Protocols under Subsection (a)(4)(D) must clearly establish procedural guidelines with criteria for testing that respect the rights of the person with the infection and the person who may be exposed to that infection. Protocols may not require the person who may have been exposed to be tested and must ensure the confidentiality of the person with the infection in accordance with this chapter.

Therefore, under these conditions, the employer may test for HIV the "source individual" (patient) of the exposure for one of his or her employees.

Do I have to secure a specific consent from the patient (source individual) to be able to test for the HIV status of the patient?

The Texas Health and Safety Code in Section 81.107 addresses this specific issue. In the case of accidental exposure of a health-care worker to blood or other body fluids, the health-care agency or facility may test a person who may have exposed the health-care worker without the person's specific consent to the tests. However, the test must be performed according to the protocols mentioned in the previous answer and those protocols must ensure that any identifying information concerning the person tested will be destroyed as soon as the testing is completed and the person who may have been exposed is notified of the result. The test result is subject to the confidentiality provisions.

Can the name of the patient (source individual) tested for HIV be made available to the employee?

The bloodborne pathogen regulation is silent as to whether or not the individual's name must be released. Certainly, the result of the test itself must be released to the employee. However, the OSHA regulation does refer and defer to state law. The Texas Health and Safety Code in Section 81.103(a) states that a "test result is confidential. A person that possesses or has knowledge of a test result may not release that test result or allow the test result to become known except as provided by this section." Section (b)(5) provides an exception for "a physician, nurse, or other healthcare personnel who have a legitimate need to know the test result in order to provide for their protection and to provide for the patient's welfare. . . ."

The Texas Health and Safety Code in Section 81.101(5) defines test result as, "any statement that indicates that an identifiable individual has or has not been tested for AIDS or HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS, including a statement or assertion that the individual is positive, negative, at risk, or has or does not have a certain level of antigen or antibody." These sections of the Health and Safety Code would indicate that the employee may be told the name of the patient (source individual), but the employee must be advised that he or she cannot redisclose that information except as permitted by law. It would be advisable to provide the employee with a copy of the relevant section of the Texas Health and Safety Code.

Are the requirements for testing and confidentiality different for HBV and HIV?

While Texas has very specific laws concerning testing, counseling, and confidentiality for HIV and AIDS, HBV has not received the same legislative attention. Therefore, Texas law concerning the testing and disclosure of information relating to HBV testing must be analyzed under different provisions of law.

The statute involved in this particular case is the Medical Practice Act of Texas, Article 4495(b), VTCS. Section 5.08(b) of the act establishes as confidential and privileged the records of the identity, diagnosis, evaluation, or treatment of a patient by a physician. In other than court or administrative proceedings, those records may be released only as permitted by the Medical Practice Act. The act specifies exceptions to the privilege of confidentiality that exist in other than court or administrative proceedings. However, the exceptions do not address releasing information concerning the HBV status without consent to an employee who may have been exposed by that patient. Therefore, the source individual (patient) must consent to the release before that information may be provided to the employee. Under the OSHA standard, if the consent is not forthcoming, then the employee must be provided with the information that the Medical Practice Act of Texas does not permit such release to him or her. It is also important to note that the source individual's consent to a test for HBV would also need to be sought and secured before that test may be performed unless a general consent for testing has been signed previously.

What are the consequences of an inappropriate release of information relating to an HIV or HBV test?

An inappropriate release of HIV information carries with it criminal penalties under the Texas Health and Safety Code. Such an offense would be a Class A misdemeanor. Under the Texas Health and Safety Code, the releasing of that information would subject the person releasing the records to injunctive action as well as civil liability. An inappropriate release of confidential information under the Medical Practice Act could subject the person releasing the information to an injunctive action as well as a civil action for damages.

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

Treatment of patients with asthma in the 1990s

GARY N. GROSS, MD

The treatment of patients with asthma in this decade requires an understanding of the inflammatory process in their airways. A combination of bronchodilators and inhaled medications that reduce or prevent this inflammatory process provides the best treatment for this population. Because the inhaled anti-inflammatory medications do not offer the immediate clinical response that bronchodilators will provide, patient education regarding proper management becomes more critical. The patient's assistance in frequently monitoring the function of the airway can help both the patient and the physician implement the necessary changes in medications to reduce the severity of or to prevent an asthma attack. Through these monitoring and treatment techniques, mortality and morbidity caused by asthma can be reduced.

Dr Gross, clinical associate professor, Department of Internal Medicine, The University of Texas Southwestern Medical School, Dallas, Tex. Send reprint requests to Dr Gross, Dallas Allergy Clinic, 5499 Glen Lakes Dr, Suite 100, Dallas, TX 75231-4307.

THE TREATMENT OF PATIENTS with asthma in this decade will benefit from advances based on the current understanding of the pathophysiology of this complex disease. Certain aspects of therapy can be addressed, however, even as mechanisms of airway obstruction are being further delineated and as more promising pharmacological agents are being developed. This review of new aspects of management will focus on pathophysiology, diagnosis, goals of therapy, medications, self-monitoring techniques, environmental controls, and patient education.

PATHOPHYSIOLOGY

Understanding the concept of airway hyperreactivity is important in designing plans for management of asthma. The airway's increased sensitivity to a variety of stimuli (eg, cold air, smoke, and strong odors) is a hallmark of the disease, and improvement of this abnormality may return the airways to a more normal state. A partial link seems to exist between hyperreactivity and airway inflammation, so most current treatment is aimed at reducing inflammation. This airway inflammation is characterized by the presence of mast cells and eosinophils. Histopathologic changes of chronic inflammation have been demonstrated even in mild disease (1). Studies have demonstrated that long-term treatment with appropriate medications can reduce reactivity to histamine and methacholine (2,3).

GOALS OF THERAPY

The primary goal in management is to "normalize" the patient's status, with a second goal of avoiding adverse reactions to medication. In "normalizing" the patient's status, the clinician hopes to optimize lung function and to achieve a normal level of activity for the patient. Reducing airway obstruction is a necessary but not a sufficient goal of therapy; reduction of airway reactivity should also be attempted.

Although plans for treating asthma often attempt to manage bronchospasm, the most apparent cause of obstruction, the other components often go untreated. The obstruction caused by production of mucus and the inflammation in these airways must be addressed to properly manage the disease. This broader approach to management must be explained adequately to the patient because the most obvious distress the asthmatic recognizes is the acute, intermittent bronchospasm. Rarely must a patient be told twice to carry a bronchodilator inhaler after experiencing the relief one offers. The added burden of normalizing sleep in this disease, which tends to have nocturnal exacerbations, must also be considered. The importance of regular exercise for the asthmatic patient adds another requirement for complete treatment, and the physician should work with the patient to develop and maintain an exercise program.

MEDICATIONS

The wide range of medications available to treat asthma may be simply divided by considering therapeutic groups. Bronchodilators offer the advantage of relaxing smooth muscle and reducing the airway obstruction caused by bronchospasm. They are primary medications to use in all patients with asthma. Bronchodilators can be used on a regular basis to promote bronchodilatation or on an "as needed" basis in some patients. These drugs alone are not sufficient

for most asthmatics because they have little, if any, effect on other causes of airway obstruction.

Bronchodilators consist of three main types: methylxanthines (eg, theophylline), ß-adrenergic agonists, and anticholinergics. Theophylline was once the mainstay of therapy for asthma, and constant *serum* levels were thought to be important. With increasing recognition of the circadian variations in airway obstruction and of nocturnal episodes of dyspnea, the benefit of "constant level" theophylline has come into question (4). The benefit of theophylline in nocturnal asthma is due partly to the availability of preparations with features of gradual release that provide peak theophylline concentrations when airway resistance would otherwise be greatest. In addition to theophylline's use in treating the nocturnal component of asthma and the drug's parenteral use in emergency room and hospitalized patients, this drug has a role in the outpatient management of the chronic asthmatic. However, the narrow therapeutic index of theophylline must be considered when the drug is used in high doses to treat outpatients (5). Serum theophylline levels should be obtained and awareness of the many drugs and conditions affecting theophylline metabolism should be discussed with the patient or parents (6). The use of theophylline in the pediatric patient bears special consideration. Higher theophylline clearance rates in children must be considered when appropriate doses are being chosen (7). Previous reports that theophylline adversely affects learning and behavior have not been confirmed in groups of patients studied (8).

ß-Adrenergic agonists are available for administration via multiple routes that include inhalation, oral (tablet and liquid), and subcutaneous. The inhalational route usually offers the fewest side effects and is preferred but not always effective. If the patient already has significant airway obstruction, the medication may not be able to reach peripheral airways.

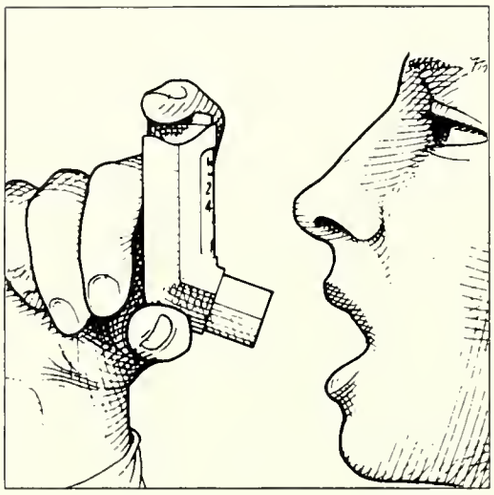
Oral ß-agonist preparations may be used by almost any age group and can provide short-term (6 to 8 hours) bronchodilator effect. Since the medication is absorbed systemically, it may cause more side effects than if the same medication were delivered directly to the airways. Oral administration may prove more effective, however, if the airways are obstructed. Parenteral administration has the potential advantage of rapid onset of action regardless of the patient's ability either to inhale or to ingest a medication.

These bronchodilators have some individual variations in onset and duration of action, but the mechanism of action of all ß-agonists is similar. Some concern has been raised as to the potential harmful effects of ß-agonists in asthma. One published study suggests that in a small group of patients who used a ß-agonist that is not available in the United States, the control of asthma deteriorated when the ß-agonist inhalant was used on a regular basis as compared with usage on an "as needed" basis (9). A study that has recently been published suggests that excessive use of ß-agonists is associated with increased risk of fatal asthma (10). Such reports of increased mortality caused by asthma underemphasize the likelihood that these severely ill patients use their ß-agonist frequently but underutilize anti-inflammatory medications. It is widely held that the ß-agonist inhalers are safe and effective if used according to established guidelines (11,12).

The anticholinergics relax smooth muscle through a mechanism that is different from those of both theophylline and the ß-agonists. The parasympathetic pathway is not clinically important in most asthmatics, and a trial of anticholinergics may be warranted in patients who do not respond to other bronchodilators. The concern that anticholinergics might thicken mucous secretions and worsen asthma has not been borne out in studies using these agents. Anticholinergics have been used in some children having bronchospasm, and these drugs should be considered when conventional therapy is not effective (13).

Anti-inflammatory agents have the advantage over bronchodilators in that they may reduce the bronchial hyperresponsiveness of the airway and, thereby, reduce the frequency and severity of asthmatic attacks. Corticosteroids have long been known to have a beneficial effect on the asthmatic patient. These drugs in the form of inhalers are now used earlier in the course of the disease (14). Corticosteroids inhaled in conventional doses are both safe and effective for most patients. These drugs should be considered as first-line therapy for patients requiring regular bronchodilators. Oral corticosteroids must be used with some caution, but these drugs, if appropriately administered, may prevent severe attacks and reduce the need for hospitalization. In one study, the early use of a short course of prednisone reduced significantly the number of asthmatic attacks occurring in a group of children who had been shown to develop asthma in association with viral infections of the upper respiratory tract (15).

Fig 1. Out-of-mouth inhaler technique.



Furthermore, these children who were treated with corticosteroids had fewer visits to the hospital. Other anti-inflammatory medications, including gold and methotrexate, have been tried in more severe and resistant forms of asthma (16,17).

Medications that have the ability to inhibit release of mediators from mast cells and possibly other inflammatory cells should prevent the asthmatic response and the subsequent hyperreactivity that have been described. Such medications (eg, cromolyn sodium) have been shown to prevent asthma if given before inhalation of an offending agent and to reduce the need for other medications in some patients (18,19). These drugs have the further advantage of reducing hyperreactivity of the airway if they are used on a regular basis. Few side effects have been attributed to the inhalation of cromolyn; therefore, this medication would meet the goals of first-line therapy. All patients will not respond beneficially to cromolyn sodium, and corticosteroid inhalants should be used in those patients who cannot use cromolyn sodium because of financial, compliance, or other considerations.

Other medications with broader antiasthma properties used currently in many countries (but not the United States) have demonstrated this cell-stabilizing effect and provide anti-inflammatory results in the airway (20). These newer agents (eg, nedocromil sodium) may offer an improvement in management by providing an effective, safe, and simple medical program for some patients. The safety profiles of cromolyn sodium and nedocromil sodium are such that the drugs deserve a trial in asthmatic patients who require regular medications to treat their symptoms.

In some situations, a known trigger may be "unavoidable." The laboratory worker sensitive to animal dander or the cat-sensitive patient visiting the home of a friend or relative who owns a cat are such situations. Cat allergen is a particularly bothersome allergen in that it remains airborne for hours, and removal of the cat from the environment does not remove the potential problem (21). Asthma may be prevented in these situations if a patient premedicates with a cell-stabilizing medication such as cromolyn sodium that will prevent the acute attack and the subsequent hyperreactivity. The preventative nature of this use must be explained carefully to the patient so that the goals of such therapy are understood and compliance is optimized.

Because many of the above described medications used to treat asthma are given by the inhalational route using metered dose inhalers (MDIs), particular attention must be paid to proper administration. Improper use of MDIs is a major reason for treatment failure, and time must be spent training patients to use these devices properly. The out-of-mouth technique is appropriate for most inhalers, except for ipratroprium bromide (Atrovent), and is preferred when using steroid inhalants (Fig 1). The use of spacer devices can reduce the pharyngeal irritation sometimes associated with inhaled medication and also can serve as a reservoir for patients whose techniques are poor. Patients should be asked to demonstrate their use of MDIs periodically to insure proper usage.

The role of antihistamines in the treatment of asthma should be reanalyzed. In the past, clinicians have been reluctant to use antihistamines in the patient with asthma for fear of thickening bronchial secretions and exacerbating the disease. This fear is largely unfounded, and most asthmatics can tolerate antihistamines without difficulty. Nonsedating antihistamines are being used widely, and some of these drugs may have beneficial effects in asthma beyond the symptomatic improvement of rhinitis. Terfenadine has been shown to inhibit the bronchospasm produced by some stimuli (22,23). These findings illustrate the changing role that antihistamines may play in the management of asthma during the coming decade.

Immunotherapy has proved effective in the management of allergic rhinitis, but the role of this form of therapy in the management of asthma has been open to question until recently. The importance of the mast cell in producing airway inflammation in asthma has revived the interest in allergen immunotherapy for this condition. Allergen immunotherapy has now been shown to be effective in reducing bronchial responsiveness to challenges by house dust mite, animal dander, and grass inhalation (24–26).

The adverse effects of many of the medications used to treat asthma can interfere with the primary goals of therapy. A methylxanthine, for instance, may be very effective but cause significant gastrointestinal upset that interferes with the daily activities of the patient. Having to take frequent medications at school or in social situations may have an adverse psychological impact on the patient. A logical approach to the management of the asthmatic patient can be devised with medications available at present and by considering changes as new modes of treatment become available during the decade.

DIAGNOSIS

A primary tenet of treatment is early intervention. This goal pertains both to early diagnosis of the disease and to early treatment of each exacerbation. To appropriately diagnose the disease, the physician must be mindful of "soft" signs and symptoms that may be the presenting features of a new asthmatic patient. The development of a dry, hacking cough lingering after a viral infection, the nocturnal cough, or the cough and shortness of breath after exercise should heighten the clinician's suspicion (27). A history of colds always "going to the chest" is another clue to the diagnosis of asthma. Regular and appropriate pulmonary function tests can help confirm the diagnosis even when no clinical signs exist. The cardinal pulmonary function finding is the reversibility of airway obstruction after the use of a bronchodilator. Measurement of the forced expiratory volume in 1 second (FEV_1) before and after an inhaled bronchodilator is often sufficient to demonstrate such reversibility. Lack of reversibility in a patient in whom the diagnosis is being considered does not rule out the disease. Sufficient inflammation or mucous plugging may be present to reduce the reversibility to insignificant levels. The use of another type of inhaled bronchodilator (anticholinergic), oral bronchodilators, or even a short (3 to 5 days) course of oral corticosteroids may demonstrate the reversibility.

SELF-MONITORING TECHNIQUES

Early intervention in the treatment of the acute episode can be facilitated if patients are aware of self-monitoring techniques. The use of regular exercise as a parameter of how the airway is functioning is a simple approach. If patients find themselves unable to complete a routine exercise that previously caused no breathing difficulty, partial airway obstruction or increased hyperreactivity not severe enough to interfere with routine daily activities may be present.

Measurements of peak flow may be used as a more objective means of self-monitoring, and the patient should keep a record of periodic measurements to see when significant reductions occur (28). These "early warning signs" help both the patient and the physician treat each episode early. Such monitoring and careful observation also help to determine specific factors that are frequently linked to an exacerbation, such as the development of an infection of the upper respiratory tract. If these associations can be made, treatment can be instituted to "prevent" asthma either by avoidance of the inciting agent or by appropriate early medical intervention.

ENVIRONMENTAL CONTROLS

A recent study suggested that the development of asthma in children prone to develop allergies may be influenced by their exposure to house dust mite antigen during infancy (29). If such were the case, an argument could be made to eliminate this antigen from the environment of these susceptible children. Agents (acaricides) are now available that can effectively reduce or even eliminate dust mites and their antigens, and further studies of these preventive techniques should be pursued. Known irritants such as cigarette smoke, aerosol sprays, and strong odors should also be avoided. Animal dander and dust may exacerbate asthma in the susceptible individual; exposure to these substances should be avoided where possible.

PATIENT EDUCATION

The best of plans for management of asthma is doomed to fail if the patient does not understand and accept it. One method of improving this mutual understanding is to write down both a list of usual medications and a contingency plan if the usual medications prove to be ineffective. Having a contingency plan gives patients more control over the disease in that there are steps they can take that do not require a consultation with a doctor. Such "control" over the disease has been identified as one feature of increased acceptance of a management plan and of willingness to take preventative medications (30). If the contingency plan also provides for the possibility of lowering medications after a certain period of optimal lung function with regular physical activity, the patient has further incentive to adhere to the program. This pa-

tient/doctor "team" approach is helpful in maintaining medication therapy, but the team must be expanded in some situations so that nonmedical treatment may be used. The addition of physical therapists, social workers, occupational therapists, and other professionals will enhance management in certain more severely asthmatic patients.

Conclusions

Greater understanding of the pathophysiology of asthma has altered our approach to treatment of this increasingly common disease. Through early diagnosis and intervention with appropriate anti-inflammatory medications and bronchodilators, most patients who have asthma should be able to function with less interference from their disease. The need for hospitalization for acute attacks should be minimized if the patient monitors peak flows and if a contingency plan is available for patient-initiated treatment. The close cooperation of the patient and health-care providers in understanding and managing this potentially fatal disease should lead to reduced morbidity and mortality.

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Management of the patient with an abnormal Papanicolaou smear

Fawzi A. Iliya, MD
Roberto Yazigi, MD

Any patient with an abnormal Papanicolaou smear should undergo colposcopic evaluation. Histologic examination of tissue obtained by biopsy and by endocervical curettage is essential for a proper diagnosis. Conization of the cervix has very well-defined indications.

From the Department of Obstetrics and Gynecology, The University of Texas Southwestern Medical Center, Dallas, Tex. Send reprint requests to Fawzi A. Iliya, MD, Department of Obstetrics and Gynecology, The University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd, Dallas, TX 75235-9032.

Carcinoma of the cervix is the third most common cancer of the female genital tract in the United States, with 13,500 new cases projected for 1992 (1). However, a steady decline in incidence and a 70% decrease in death rate has occurred over the last 40 years (2), most likely due to the early detection of preinvasive disease in asymptomatic women by the use of exfoliative cytology (Papanicolaou smear).

PAPANICOLAOU SMEAR

Approximately 35,000 Papanicolaou smears are screened each year at the cytology laboratory of Parkland Memorial Hospital, and approximately 700 patients with abnormal Papanicolaou smears are appointed monthly at the Dysplasia/Colposcopy Clinic. The descriptive terminology used for reporting Papanicolaou smear results is shown in Table 1. Emphasis is placed on the presence of endocervical cells and/or mucus, which determines the adequacy of the sample. Some cytologists believe that the mere presence of metaplastic squames on the smear indicates adequacy, since the transitional zone must have been sampled.

Table 1. Reporting of Papanicolaou smears at Parkland cytology laboratory.

Negative	
Atypical (inflammatory or uncertain)	
HPV cytopathy	Low-grade SIL
Dysplasia minimal	Low-grade SIL
Dysplasia moderate, severe	High-grade SIL
Carcinoma in situ	High-grade SIL
Squamous cell carcinoma	
Adenocarcinoma	

HPV = Human papilloma virus
SIL = Squamous intraepithelial lesion

The Bethesda System for reporting cervical/vaginal cytological diagnosis was developed in 1988 (3). Remarkable among the changes is the introduction of the new terms defined as low- and high-grade SIL (squamous intraepithelial lesion); these changes still provide for cytopathologists who wish to add the degree of dysplasia or grade of CIN (cervical intraepithelial neoplasia). Cellular changes associated with the human papilloma virus (HPV) may be noted separately, but the recommendation is to classify them as low-grade SIL. The inclusion of human papilloma virus cytopathic effect within the category of intraepithelial lesions, as well as the inclusion of moderate and severe dysplasia in the same category (high-grade SIL), has been challenged by some authors (4).

THE ATYPICAL PAPANICOLAOU SMEAR

Approximately 8% of all Papanicolaou smears examined at Parkland are interpreted as having cells with atypical features. These are nonspecific cellular changes caused mostly by infection (fungal, bacterial, protozoan, or viral), by reactive cellular changes associated with inflammation and atypical squamous metaplasia, and by estrogen deficiency in postmenopausal women.

Our recommendation for most of these cases with abnormal results is to treat the underlying cause if identified and repeat the Papanicolaou smear in 3 months. If the results of the repeat smear are normal, a follow-up in a year would be adequate management. However, if the possible etiology is not identified, if the

atypicality persists despite therapy, or if a cytopathic effect consistent with HPV or any degree of dysplasia is suggested, then colposcopic evaluation is mandatory. Of 1,525 women with atypical Papanicolaou smears who underwent colposcopic evaluation with cervical biopsies, results of the biopsies showed 328 (22%) had CIN with 56% of these 328 patients having CIN II or CIN III (5–8).

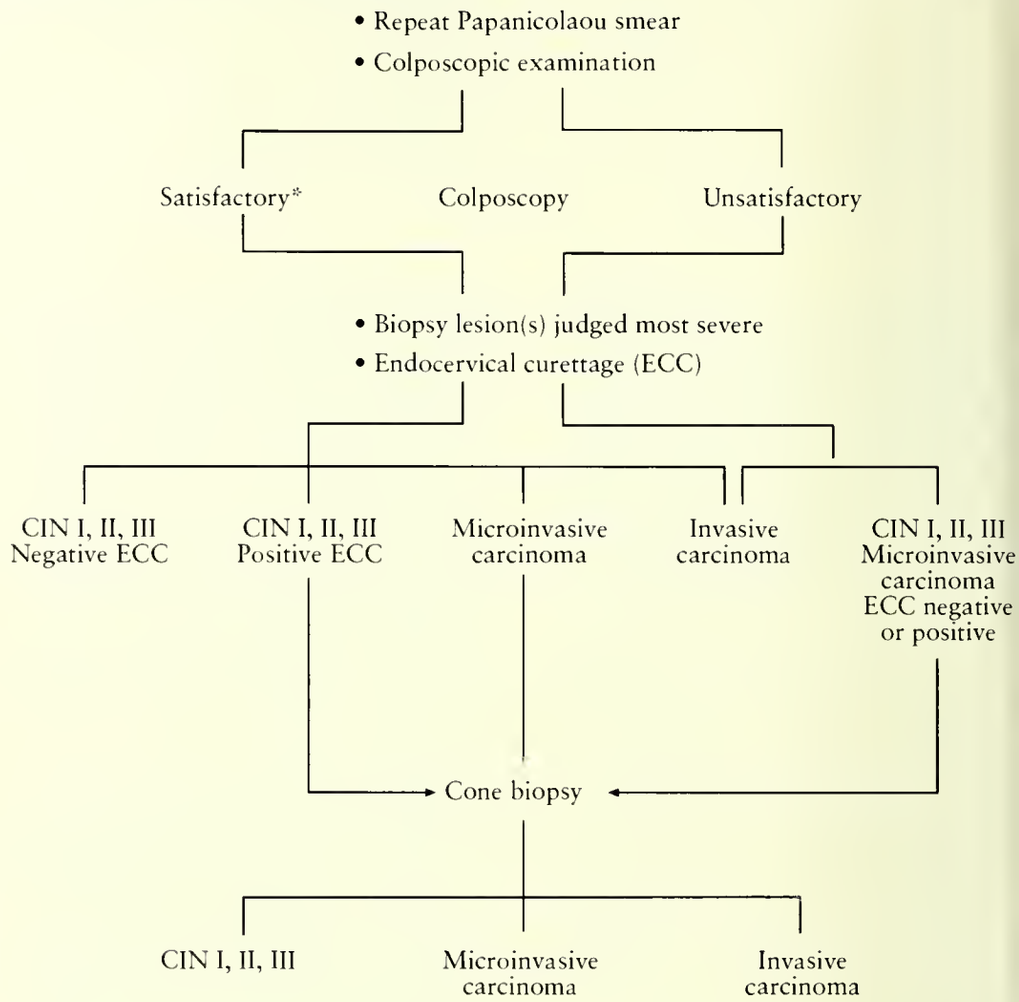
CYTOPATHIC EFFECTS OF HUMAN PAPILLOMA VIRUS

Approximately 11% of our Papanicolaou smears show features that suggest the presence of HPV infection. These features include mainly cellular changes that are designated by cytopathologists as "koilocytosis" (cells with perinuclear halos) and dyskeratosis. Most genital HPV infections are subclinical, becoming visible only after acetic acid is applied to the cervix. Patients with these infections should undergo colposcopic evaluation with biopsies to determine the nature of the lesions (flat condyloma alone and/or an intraepithelial lesion).

Table 2. Colposcopic terminology.

Normal findings
Original squamous epithelium
Columnar epithelium
Transformation zone
Abnormal findings
Atypical transformation zone
Acetowhite epithelium
Punctation
Mosaic pattern
Leukoplakia (keratosis)
Abnormal blood vessels
Suspect frank invasive cancer
Other findings
Vaginal cervicitis
True erosion
Etropic epithelium
Condyloma, papilloma

Fig 1. Evaluation of the abnormal Papanicolaou smear.



* For a colposcopic examination to be satisfactory, the epithelium between the original and active squamocolumnar junctions (transformation zone) must be completely visualized.

CIN= cervical intraepithelial neoplasia.

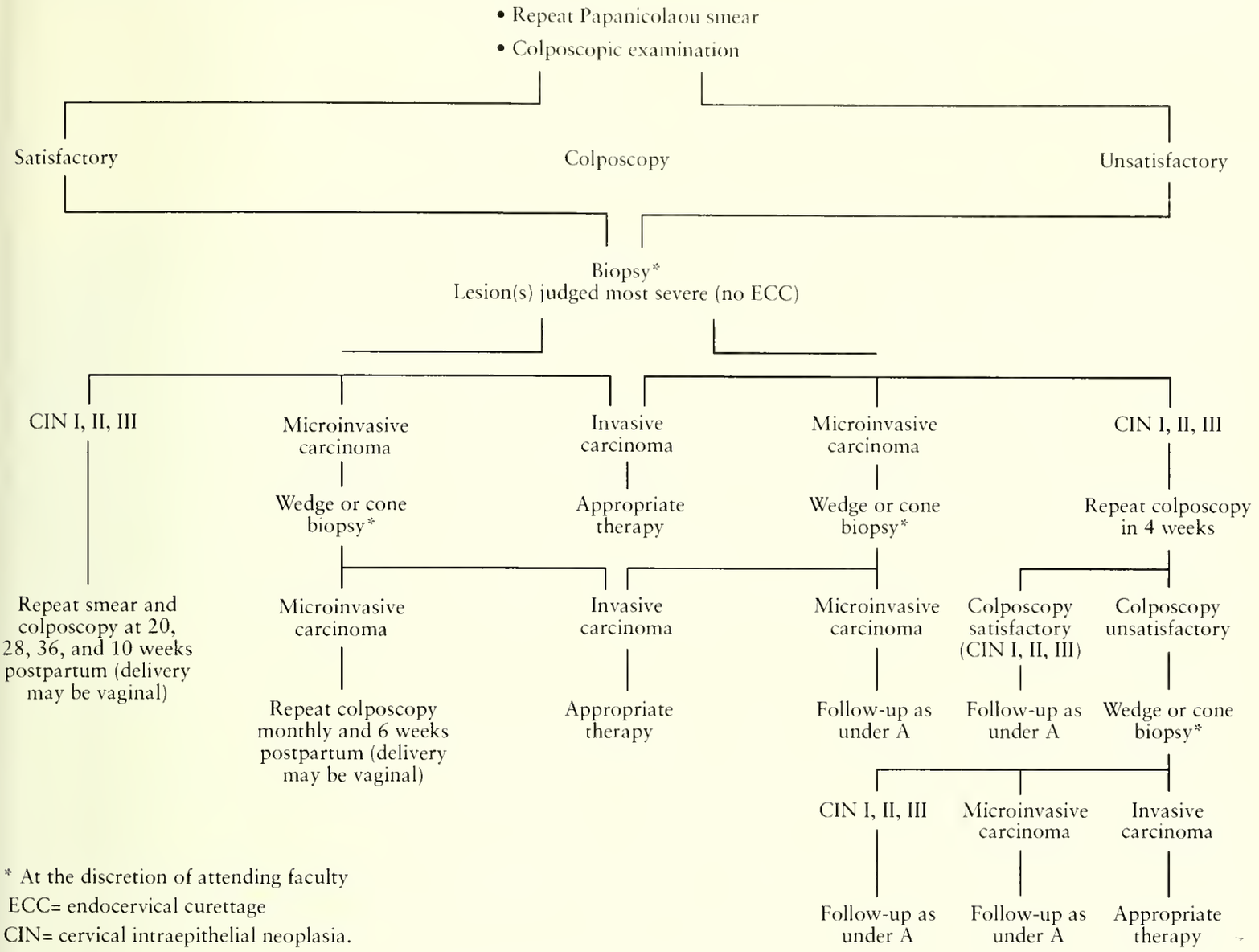
Campion and colleagues (9) documented the progressive potential of mild cervical dysplasia. Twenty-six percent of the women studied progressed to biopsy-proven CIN III within 2 years. Human papilloma virus type 16 was identified in 85% of women with rapid progression of disease. Campion estimated that more than 30% of women whose smears showed evidence of HPV infection would have biopsy-proven cervical neoplasia.

COLPOSCOPY

Colposcopy is performed whenever the Papanicolaou smear is suggestive of intraepithelial disease or HPV infection. The site where most squamous cell cervical neoplasias originate is the transformation zone, and this area needs to be evaluated carefully by colposcopy. Any suspicious lesion should then be biopsied. The colposcopic image depends on the surface epithelium, cell number, morphology, arrangement, and, above all, the vascular pattern within the connective tissue stroma. The terminology used for colposcopic evaluation is shown in Table 2. The squamocolumnar metaplastic process and the development of the transformation zone have been analyzed in detail by Burke (10).

Colposcopy is considered satisfactory when both the whole lesion and the transformation zone are entirely visible; this concept is of paramount importance for future therapeutic considerations (Figs 1 and 2). With a satisfactory colposcopy, several clinical conditions become apparent. Those patients with any grade of CIN and a benign ECC (endocervical

Fig 2. Evaluation of the abnormal Papanicolaou smear in pregnancy.



curettage) can be treated conservatively on an outpatient basis if the topography of the cervix and the size of the lesion allow. Those who present a positive ECC or have an unsatisfactory colposcopy, in addition to those with the diagnosis of microinvasive carcinoma based on results of biopsy, should then undergo conization of the cervix. The cone biopsy is frequently both diagnostic and therapeutic.

The management during pregnancy follows the same guidelines with a few exceptions. In the first half of pregnancy, cervical biopsies may be obtained but no ECC is done. Later in pregnancy, the decision of obtaining a biopsy must be based on the gestational age and the severity of the cytologic and colposcopic findings. Colposcopy in pregnancy is usually satisfactory, with the transformation zone completely visualized; if not, a colposcopy repeated in 4 to 6 weeks could enable the examiner to visualize this zone in most cases. A cone biopsy is best avoided during pregnancy except when ruling out an invasive carcinoma becomes imperative. Neither the presence of CIN nor that of microinvasive disease constitutes a definite contraindication for vaginal delivery.

Although colposcopy is by no means diagnostic, our physicians are encouraged to commit themselves to a colposcopic impression of the expected histopathologic diagnosis of the biopsies obtained. This grading is essentially based on the surface lesion, its margins, and, particularly, the vascular pattern (11,12). We do not follow a scoring system, although it has been recommended (Table 3) (13).

In bimonthly conferences with the pathologist and the cytologists, we analyze difficult cases by reviewing the material available and decide on the management. These meetings constitute an outstanding teaching and learning experience.

Table 3. Colposcopic index according to Reid and Scalzi (13). Scores of 0 to 2 indicate mild dysplasia to cervical intraepithelial neoplasia (CIN) I; 3 to 5, CIN I to CIN II; 6 to 8, CIN II to CIN III.

Criterion	Range
Lesion color	0–1–2
Margins	0–1–2
Vascular pattern	0–1–2
Iodine staining	0–1–2

CERVICAL BIOPSIES

Any macroscopic lesion of the cervix should be biopsied, regardless of the cytologic report. Under ideal conditions, the cervical biopsies should be guided colposcopically to improve the accuracy of the sample. The biopsy instruments vary according to shape but basically accomplish the same purpose in obtaining tissue for histopathologic evaluation. We favor the Kevorkian punch and the Tischler biopsy forceps.

ENDOCERVICAL CURETTAGE

Endocervical curettage is an adjunct to the colposcopic examination of patients with abnormal Papanicolaou smears. At our institution it is performed in all patients. Although easy to perform, ECC is considered by the patients to be the most uncomfortable part of the entire evaluation. We use the Kevorkian curette, which can be easily introduced 2 to 3 cm into the canal without anesthesia. Samples are obtained by four strokes, covering each quadrant of the endocervical canal. The terminology for histopathologic findings is shown in Table 4.

In approximately 50% of the samples, our pathologists are unable to accurately grade the dysplasia. In an effort to determine the value of this method, we studied 234 Parkland patients on whom an ECC was performed as part of the routine evaluation. Of the women who had satisfactory colposcopies, 73% had benign results from the ECCs. Of those who had unsatisfactory colposcopies, only 43% had benign results from the ECCs. We consider the ECC mandatory in those cases with unsatisfactory colposcopy and recommended in all others (except for pregnant patients or those with acute inflammatory disease).

Table 4. Histologic findings in samples from endocervical curettage.

Benign endocervical tissue
Condylomatous changes
Dysplasia (slight, moderate, severe)
Carcinoma in situ
Dysplasia not otherwise specified
Malignant tissue
Endometrial tissue
Insufficient for diagnosis

CONIZATION

The advent of colposcopy and the directed cervical biopsies have decreased the rate of cervical conization performed in patients with abnormal Papanicolaou smears to roughly 15% to 20%. Conization of the cervix involves risks and complications that must be justified by well-defined indications. These include unsatisfactory colposcopy with cervical biopsies showing high-grade dysplasia, findings from endocervical curettage that show dysplasia, need to rule out a diagnosis of microinvasive or invasive cancer of the cervix, discrepancy between Papanicolaou smear and cervical biopsy of more than 1 degree, and therapeutic purposes in selected cases.

The purpose of conization is to remove tissue necessary for diagnosis. In most cases, this procedure will also be therapeutic. Use of Lugol's solution or the colposcope to outline the limits of the abnormality is helpful. An ECC should be performed after the conization has been completed. If the histopathologic findings from the cone margins are negative for neoplasia, we recommend evaluation with Papanicolaou smear every 6 months for 2 years, followed by annual examinations. If the findings from the margins are positive for intraepithelial disease, the alternatives vary from careful observation to another conization or even to hysterectomy, according to patients' circumstances but mostly to the degree of dysplasia.

Complications from the procedure may include hemorrhage requiring transfusion, cervical stenosis, premature labor, uterine perforation, pelvic cellulitis, and, rarely, injury to the bladder or rectum.

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RDIOLOGY

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BC invasive cardiologist needed for associate ctice in north central Texas community of oximately 21,000 (serving referral area of 206,000). ional medical center with modern facilities and pment; all medical specialties and cardiovascular gery back up. Area renown for recreational enities. Easy access from Dallas/Fort Worth opolitan area. Contact: Vicki Truitt.

MILY PRACTICE

T TEXAS
nancially sound, 48-bed hospital seeks board ified (or eligible pursuing certification) family sician to establish a solo practice. Call sharing and erage is available from other family physicians in the mmunity. This beautiful rural community is a eational mecca; hunting, fishing, water sports, ping, etc. Competitive incentive package to lified physician. Contact: Barry Strittmatter.

T TEXAS
board certified, recently trained family physicians seeking additional family physician for associate ctice (or solo sharing call) in small university town in one hour of D/FW Metroplex. No OB. Great life e among sophisticated population without the sles of, but access to, a large city. Lots of eational and social amenities. Generous incentive kage from community hospital to qualified doctor. ntact: Barry Strittmatter.

PASO
ighly respected and well-established physician in El so (population approximately 500,000), wishes to e. He and the hospital with whom he is associated k a board certified (or board eligible pursuing tification) family physician to join him and begin to ume his large practice. Competitive benefit package qualified candidate. Contact: Barry Strittmatter.

RTH CENTRAL TEXAS
at location! Tremendous need for primary care! Call aring available, or bring a friend/colleague and ctice together in this north central Texas community approximately 21,000 (serving referral area of ,000). Regional medical center with modern facilities d equipment. Generous incentive package. Area own for recreational amenities. One hour from llas/Fort Worth metropolitan area.
ntact: Vicki Truitt.

RT WORTH
gest family practice residency program in the country eks division director to coordinate faculty velopment, (clinical) research and grant activities. sition encompasses teaching, patient care and ministrative responsibilities. Prefer physician with rural actice experience; board certification required. Clinical sistant professorship appointment to major medical school; good income and benefits; little to no call. Join the team and enjoy your profession!
Contact: Vicki Truitt.

INFECTIOUS DISEASE

FORT WORTH
ID physician or internist needed to manage infectious disease service of major teaching hospital in D/FW Metroplex (100% ID practice). Service includes 10-bed inpatient infectious disease unit and outpatient infectious disease clinic; modern infusion lab. Intern and resident assigned to service. Great position; 40-hour work week and very limited call responsibility; excellent income and benefits. Contact: Jim Truitt.

INTERNAL MEDICINE

D/FW METROPLEX
BC internist needed to fill the position of Director, Department of Internal Medicine of major teaching hospital. Individual selected must possess strong administrative skills, be an effective communicator, committed to primary care medicine, dedicated to quality medical education and willing to provide some direct patient care. Five day work week, superb income, benefits and faculty appointment will be offered to qualified individual. Contact: Jim Truitt.

SOUTH TEXAS
Thirty minutes from Padre Island. IM group, specializing in critical care, seeks third compatible associate. Great climate and lifestyle. Recreational opportunities abound. Guaranteed income with high monetary potential. Contact: Barry Strittmatter.

FORT WORTH
BC internist needed to see patients in general medicine clinics and accommodate IM consultations in community based health clinics. Five-day work week, regular hours. Superb income and benefits. Great opportunity for interesting practice and excellent life style.
Contact: Jim Truitt.

NEUROLOGY

NORTHEAST TEXAS
Regional medical center serving 200,000 seeks BE/BC neurologist for practice; fee for service; shared call. Modern medical facilities. 100+ doctors in town. Progressive, family-oriented community with strong, diversified economy, excellent schools. Many social and recreational opportunities. Generous incentive package to qualified physician.
Contact: Barry Strittmatter.

OBSTETRICS/GYNECOLOGY

NORTH CENTRAL TEXAS
BE/BC OB/GYN needed for associate practice in north central Texas community of approximately 21,000 (serving referral area of 206,000). Regional medical center with ultra-modern OB facilities and equipment. Good neonatal support. Area renown for recreational facilities. One hour from Dallas/Fort Worth metropolitan area. Contact: Vicki Truitt.

ONCOLOGY

FORT WORTH
Full time medical oncology position at teaching hospital in D/FW Metroplex, clinical teaching appointment to UT medical school. Manage oncology division, develop full time oncology teaching service. Utilize modern facilities; infusion lab. Regular hours and limited call. Attractive income and benefits. Contact: Jim Truitt.

OTOLARYNGOLOGY

NORTH CENTRAL TEXAS
Regional medical center in community of approximately 21,000 (serving referral area of 206,000) seeks BC otolaryngologist. Associate or solo practice possibilities. Ultra-modern hospital facilities. Area renown for recreational facilities; easy access to D/FW Metroplex. Competitive incentive package to qualified physician. Contact: Vicki Truitt.

PEDIATRICS

NORTH CENTRAL TEXAS
Recently trained, BC female pediatrician seeks compatible associate for private practice. Four-way shared call; superb hospital facilities; Level II nursery. Competitive income and benefits. Attractive area with easy access to Dallas/Fort Worth. Contact: Vicki Truitt.

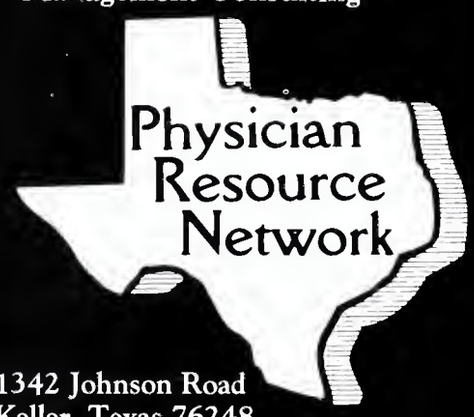
SOUTH TEXAS
Pediatric group practice. Three American-trained, board certified pediatricians seek compatible associate to join rapidly growing practice in the Rio Grande Valley. Excellent income potential in an area acclaimed for its great climate and recreational opportunities.
Contact. Barry Strittmatter.

NORTHEAST TEXAS
Dynamic group of American trained, BC pediatricians seek fourth associate for group practice in attractive community of 27,000 (referral area of 200,000). Progressive, family-oriented community with strong, diversified economy; excellent schools. Social and recreational opportunities abound. Modern hospital with Level II nursery and designated pediatric care unit. Shared call; excellent income and benefits; early partnership. Contact: Vicki Truitt.

PULMONARY MEDICINE

FORT WORTH
Immediate need for fellowship trained pulmonary medicine specialist to accommodate full time, 100% pulmonary and critical care consultative service. Teaching hospital, resident supervision. Limited weekend and evening call responsibility; coverage available from BC pulmonologist. Great opportunity for interesting practice with excellent life style. Good income and benefits. Contact: Jim Truitt.

■ Physician Search & Placement
■ Medical Practice Appraisal, Brokerage, Establishment & Management Consulting



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Practices

Selling Your Practice? We offer practice evaluations & brokerage, physician recruiting, and partnership buy-in services. We can help you make the right decisions. For a free brochure, call or write: PRACTICE DYNAMICS, Dept T, 11222 Richmond, Ste 125, Houston, TX 77082; 713-531-0911.

For Sale — Large well-established solo family practice midway between Dallas/Fort Worth, Texas. Excellent hospital facilities nearby. MD will stay and introduce new physician, plans retirement. Reply to Ad Box 798, 401 West 15th St, Austin, TX 78701.

Houston — Southeast. Exceptional opportunity to take over fully established practice from nationally recognized orthopaedic surgeon. Stable, diversified growing referral base. Outstanding income potential. Superior opportunity for physician interested in industrial and sports medicine. Ergonomically functional clerical/clinical office. Beautiful modern decor. Professional management and clerical staff, physical therapy and radiology. State-of-the-art computer system. Proximate to Houston's Astrodome, industrial centers and nationally recognized school systems. Near seven community hospitals. Easy access to Houston's world renowned medical center, cultural centers, and Clear Lake's beautiful recreational community. Ms Collier 713-922-5882.

Houston — Quality practice with excellent medical reputation. Large patient base. Doctor retiring, will stay for transition. Located just outside metroplex. Contact Business & Professional Associates 713-782-8888. TDH1402.

Family Practice for Sale: Grossing $500K, Houston, Texas. For more information, please call Jack Clark at 713-579-2575.

Internal Medicine/Pulmonary Practice — For sale in West Texas. Grossing $500K+. Contact: Please call 915-337-5223.

Suburban Metroplex — Well established General Surgery practice is available. Collections in excess of $330,000 for 1991. Prestigiously located office is fully computerized. Thorough and generous introduction. Courteous and efficient staff will stay, if desired. For information, confidentially contact AD Box 803, 401 West 15th Street, Austin, TX 78701.

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Major John Terry (512) 829-4554

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CME / Continuing Education Directory

Courses

SEPTEMBER

Cardiology

Sep 14–17, 1992
Clinical Electrophysiology: Cardiovascular Board Review. Philadelphia. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Sep 17–19, 1992
Colloquium on Cardiovascular Therapy. Santa Fe, NM. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Sep 21–23, 1992
Clinical Application of Echocardiographic Techniques. Indianapolis. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Sep 21–22, 1992
Interventional Cardiology: Aspirations for 1992 & Beyond. Boston. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Dermatology

Sep 11–12, 1992
Wound Care: A Team Approach. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Emergency Medicine

Sep 19, 1992
EMS Update 1992. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Internal Medicine

Sep 8–13, 1992
Intensive Review of Internal Medicine. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Obstetrics and Gynecology

Sep 12–13, 1992
Transvaginal Sonography. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Sep 25–26, 1992
Annual Seminar on Obstetrics & Gynecology. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Ophthalmology

Sep 10–12, 1992
Welsh Cataract Congress. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Sep 10–13, 1992
Uveitis & Retinal Frontiers. Carmel, Calif. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

Sep 18–19, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Psychiatry

Sep 24–27, 1992
Multiplicity of Approaches to Treatment of Multiple Personality Disorder. Austin. Contact Don Young, Shoal Creek Hospital, 3501 Mills Ave, Austin, TX 78731 (512) 452-0361

Sep 26–Oct 28, 1992
Psychoanalytic Concepts of Character: Theory & Practice. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Risk Management

Sep 17, 1992
Malpractice in the Rio Grande Valley: Case Analysis & Review. Harlingen. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Sep 19, 1992
From Deposition to Courtroom. Austin. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411

Sep 19–20, 1992
Grand Rounds in Medical Malpractice. Harlingen. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Sep 24, 1992
Grand Rounds in Medical Malpractice. Lubbock. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

OCTOBER

Cardiology

Oct 1–2, 1992
Cardiology Update. Carmel, Calif. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Dermatology

Oct 14–16, 1992
Experience in MDA-ALS Clinic. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Oct 17–18, 1992
The Skin from A to Z. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

General Medicine

Oct 15–16, 1992
Disability, Chronic Illness & Access to Health Care. Houston. Contact Health Law and Policy Institute, University of Houston Law Center, Rm 104 TU2, Houston, TX 77201-6381 (713) 743-2106

Oct 31, 1992
Diabetes Update. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Genetics

Oct 2, 1992
The Shape of Things to Come: Genetics for Clinic, Classroom & Community. Temple. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Obstetrics and Gynecology

Oct 31–Nov 1, 1992
Transvaginal Sonography. Houston. Contact Department of Education, American Academy of Pediatrics, PO Box 927, Elk Grove Village, IL 60009-0927 (800) 433-9016

Oncology

Oct 10–13, 1992
Pharmacy Symposium on Cancer Chemotherapy. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Oct 17–23, 1992
Symposium on Fundamental Cancer Research. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Oct 20–23, 1992
Immunobiology of Cancer Research Symposium: Molecular and Cellular Mechanisms. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Ophthalmology

Oct 2, 1992
Cataract 1992. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Pediatrics

Oct 1–2, 1992
Perinatal Seminar. Temple. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Oct 16–17, 1992
Subspecialty Pediatrics for the Primary Care Physician. Dallas. Contact A. Webb Roberts Center for CME, Baylor University Medical Center, 3500 Gaston Ave, Dallas 75246 (214) 820-2317

Oct 23–24, 1992
Pediatric Postgraduate Course. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Risk Management

Grand Rounds in Medical Malpractice. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518
Oct 1, 1992 — San Antonio
Oct 3–4, 1992 — San Antonio
Oct 8, 1992 — Dallas
Oct 10, 1992 — New Orleans
Oct 24–25, 1992 — Houston

NOVEMBER

Computer Applications

Nov 7, 1992
GRATEFUL MED: Computer Access to Information. Austin. Contact Texas Medical Association Library, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1547

Emergency Medicine

Nov 19–20, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact Humana Women's & Children's Hospital, 8109 Fredericksburg Rd, San Antonio, TX 78229 (512) 692-5191

General Medicine

Nov 21, 1992
Hyperlipidemia Seminar. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Neurology

Nov 13–15, 1992
Update & Review in Neurology. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Oncology

Nov 6–10, 1992
International Symposium on Polyamines in Cancer. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Otolaryngology

Nov 5–7, 1992
Otolaryngology Update. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

Nov 5, 1992
Pediatric Advanced Life Support Renewal Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Nov 6–7, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Psychiatry

Nov 13–15, 1992
Group Therapy Symposium. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Risk Management

Nov 19, 1992
From Deposition to Courtroom. San Antonio. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411

Nov 21–22, 1992
Grand Rounds in Medical Malpractice. Dallas. Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

DECEMBER

Oncology

Dec 5, 1992
Cancer Update: Melanoma/Sarcoma. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Dec 5, 1992
Laparoscopy & Thoracoscopy in Cancer Management. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Ophthalmology

Dec 10–11, 1992
Glaucoma Management. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Risk Management

Dec 5, 1992
Grand Rounds in Medical Malpractice. San Antonio. Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Risk Management Seminars

The following course is sponsored by the Texas Medical Association through its Practice Management Department. All seminars, unless otherwise announced, will be held from 7 pm–10 pm. For further information, contact the TMA Risk Management Office, 401 W 15th St, Austin, TX 78701 (512) 370-1411.

Aug–Nov, 1992

From Deposition to Courtroom
Aug 27, Houston
Sep 19, Austin (during TMA Fall Leadership Conference; 2–5 pm)
Oct 22, Dallas
Nov 19, San Antonio

Calendar of Meetings

•Denotes Texas meeting

September

Sep 11–13, 1992, El Paso
•*Texas Society of Anesthesiologists Annual Meeting*
Contact TSA, 401 W 15th St, Ste 990, Austin, TX 78701 (512) 370-1659

Sep 19, 1992, Austin
•Texas Medical Association Fall Leadership Conference
Contact Jon Hornaday, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1345

Sep 25–26, 1992, Irving
•*Texas Pediatric Society Annual Meeting*
Contact Texas Pediatric Society, 401 W 15th St, Austin, TX 78701 (512) 370-1527

Sep 27–30, 1992, Houston
•*Texas Technology Transfer Association*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Sep 29–Oct 4, 1992, Quebec
American Society of Cytology Annual Scientific Meeting
Contact Yener S. Erozan, MD, 1015 Chestnut St, Ste 1518, Philadelphia, PA 19107 (215) 922-3880

October

Oct 22–25, 1992, San Diego
American Pain Society Annual Meeting
Contact APS, 5700 Old Orchard Rd, 1st Floor, Skokie, IL 60077-1057 (708) 966-5595

Oct 31–Nov 4, 1992, Dallas
•*Pan American Medical Association Quincentenary Congress*
Contact PAMA, 3600 Gaston Ave, Ste 1051, Dallas, TX 75246 (214) 824-2087

November

Nov 1–2, 1992, Phoenix
Leukemia Society of America Symposium
Contact LSA, 733 Third Ave, New York, NY 10017 (212) 573-8484, ext 138

Nov 18–21, 1992, Houston
•*American Association for Cancer Education*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

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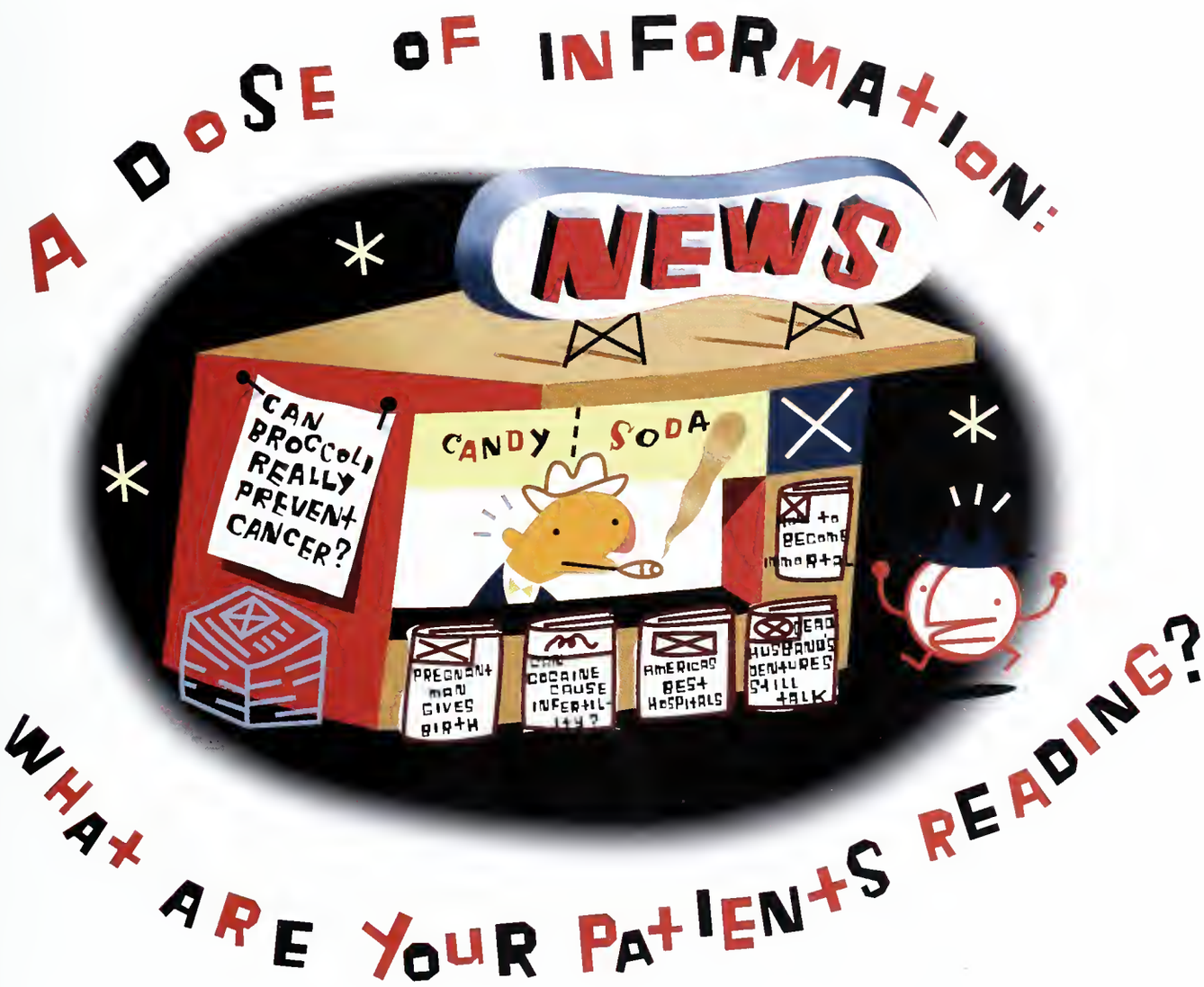

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TexasMedicine

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Texas Medicine Feature

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"Our patients' thirst for medical information is astonishing."

— John W. Burnside, MD

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- Learn from M. Roy Schwarz, MD, AMA Senior Vice President of Medical Education and Science, about physician and patient fears of HIV.
- Get an insider's look from Texas legislators at the Texas Health Policy Task Force and sunset review of the Medical Practice Act.
- Take a colorful look at state and national politics with *Texas Monthly* Executive Editor Paul Burka during the complimentary luncheon from Texas Medical Liability Trust.
- Discover ways to reduce hassles brought on by Medicare's RBRVS and learn to combat family violence during two special sessions.

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Letters

It's time to ration health-care technology

After attending a recent legislative conference in Washington, DC, I believe I have a better focus on some of the problems of our health-care delivery system.

The concerns I heard expressed by our politicians centered around how to increase access to the system while lowering cost. But this can only work if health care is rationed.

The chief underlying problem with our system is cost — we spent about $2,600 per person for health care last year — and the real villain is the cost of technology.

Fifteen years ago, when grandfather came to the emergency room with chest pain, he was hospitalized for a week with his myocardial infarction. If he survived, he left with a $6,000 or $7,000 bill. Today, when grandfather has chest pain, he is stress-tested, catheterized, angioplastied, and bypassed. If things go well, he will generate a $50,000 hospital bill. If there are problems, his cost may be $300,000 or $400,000, with questionable improvement in the quality of his life in comparison to the much less expensive care he would have received more than a decade ago.

Similarly, we dialyze everyone with renal failure, regardless of mental status, and frequently prolong life with no consideration for quality of life.

Another example is the 2-year-old who lacerates his head on the coffee table. In the past, this injury would have been cared for in the emergency room with digital palpation, suturing, and instructions for the parents to look for changes in mental status. This would have cost about $75. Now the legal standard of care for this same injury might include a skull series and CT scan with an overnight admission and a cost of $1,500 or more. Can we afford the cost of this technology to screen for the one or two patients in 10,000 who might have sustained an intracerebral injury?

Rationing technology cannot work if it is left up to families and physicians. Because of the guilt of "not doing everything possible," families can't be expected to choose the most cost-effective treatment options. And given our legal climate, physicians must practice defensive medicine, which means doing every test and offering every treatment to avoid being held accountable later by our plaintiff-driven judicial system.

Limiting technology through practice guidelines is the only hope to control escalating health-care cost. We as a caring society must make these hard decisions and decide what care is cost-effective and who receives that care.

David C. Powell, MD
690 19th St
Beaumont, TX 77706

Express your point of view in Texas Medicine

To submit a letter, send it to Texas Medicine, *TMA, 401 W 15th St, Austin 78701. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.*

Sunset is golden opportunity to make changes at TSBME

Apropos "The Voice of Medicine" (*Texas Medicine*, May 1992, pp 34–44), the investigative division of the Texas State Board of Medical Examiners (TSBME) has become another source of aggravation and outright interference in our private practices.

The Medical Practices Act, January 1980, intends — correctly — that direct patient care complaints be investigated. But, investigators have extended their powers, first to indirect care complaints, then to non-care complaints, then to complaints involving all of the physician's medical practice, and, finally, to every aspect of the physician's life, medical or not.

As one investigator wrote, "our rules and Legislation do authorize and require us to investigate any allegation of any nature made by anyone that concerns a physician" . . . whether the complaint is withdrawn or not!

I believe this is political control of medicine at its worst. No one at TSBME is accountable to you or your attorney. With the Sunset Act, we have an opportunity to shape the Medical Practice Act of 1993. I urge you to speak out in our journals, societies, and to our legislators. Especially meet with Rep David Cain, PO Box 2910, Austin, TX 78769, (512) 463-0476. He is chairman of the Sunset Commission that is conducting statewide hearings at this time. Also contact Charla Ann Baker, Sunset Advisory Commission, PO Box 13066, Capitol Station, Austin, TX 78711, (512) 463-1287.

Do it now — or don't mourn later.

Willard S. Gold, MD
1127 Judson Rd, Suite 136
Longview, TX 75601

IN RESPONSE

IN RESPONSE TO DR GOLD'S letter, I agree that the board does have broad powers of investigation. However, I would disagree that the board can deal with "every aspect of the physician's life, medical or not." It is not clear what Dr Gold means by "indirect care complaints" and "non-care complaints," but I agree that "complaints involving all of the physician's medical practice" are of concern to the board.

The legislature has specified 21 items in Section 3.08 of the Medical Practice Act for which the board may refuse to issue a license. These have become the standards for disciplinary action as well and include such non-care items as altering any medical license, certificate, diploma, etc; use of any advertising statement that is false, misleading, or deceptive; and failure to release records. Most of the other items deal more directly with patient care.

The mandate of the TSBME is to protect the public. The board does this by issuing licenses only to those who are qualified and by receiving allegations, investigating them, and holding informal and formal hearings about those allegations that appear to have validity.

The board is accountable to the Oversight Committee of the Senate, to the various other agencies to which we have to make reports concerning our activities, and to the legislature every 2 years when we seek our funding.

I would welcome the opportunity to discuss with Dr Gold the specifics behind his concern. I would agree that anyone who has concerns should address them to the Sunset Advisory Commission. I am always available to discuss the board and its functions.

Homer R. Goehrs, MD
Executive Director
Texas State Board of Medical Examiners
1812 Centre Creek Dr, Suite 300
PO Box 149134
Austin, TX 78714-9134

What he left behind

TO MANY, THE ACCOMPLISHments that mean the most are those achieved while one is still alive. These may be in the form of monetary accumulation, academic achievement, or the way one's efforts benefit others.

But for some, through circumstances beyond their control, efforts to reach their goals are cut short. This "failure" may come in the form of illness or injury. For others it might be due to death or the loss of a loved one. In any case, we may wonder how to judge the accomplishments of those unfortunate individuals. Did their shortened or altered lives stand for something? The answer can only come through others who live after and the changes they undergo because of those who went before.

Some of man's greatest achievements are recognized only after death. Many artists die in obscurity and poverty, only to be fully appreciated years later. For many, their greatest achievements come because of their ability to face adversity. They are judged by this courage and dignity in the face of hopeless odds. It is this strength that inspires others to face problems of their own.

The son of one of our organization's most respected members recently lost his struggle with cancer. He was a brilliant student in the mid-years of his college career at the Naval Academy when the cancer was first discovered. Upon graduation, he planned to enter the field of aerospace medicine.

But his goals changed: following his diagnosis, he was just fighting to survive. He never lost his optimism, hoping someday to become an oncologist in order to help others who had problems similar to his own. He also never lost his courage. He was willing to undergo any therapy, regardless of the risks, if there was any chance it would help in his battle. His efforts were an inspiration to all he knew.

In the end, he lost the battle, but he left behind a legacy that gives strength and courage to many others who will face similar problems in the future.

Rob, you are gone, but you will never be forgotten.

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R.M. Tenery, Jr, MD
President-elect, Texas Medical Association
7777 Forest Lane, A-353
Dallas, TX 75230

RBRVS: the first 6 months

JANUARY 1, 1992, MARKED the dawn of the Resource Based Relative Value Scale (RBRVS), but the new payment method still has not provided enough daylight for most physicians to know whether to expect income gains or losses. In the

meantime, the Health Care Financing Administration (HCFA) has tried to refine the Medicare Fee Schedule in order to fulfill its promises of understanding and fairness made to the medical community.

Among the changes HCFA has made are:

- Although most services performed by new physicians will be paid at a reduced rate, HCFA — in accordance with law — has exempted a whole series of primary care services from this cut. New physicians will be paid at the full Medicare Fee Schedule rate for 38 primary care service codes. They include codes 99201–99215 for evaluation and management services, 99281–99285 for emergency room, 99321–99333 for domiciliary, 99301–99313 for nursing homes, 99341–99353 for home visits, and 92002–92004 for new patient, eye examination.
- HCFA continues to alter differential payments based on the site of service. A new rule calls for a 50% reduction in the practice expense component of the payment equation for 333 procedures when the procedure is performed outside the office, regardless of geographic location. If the listed procedure is performed in a hospital outpatient area, it will be paid, on the average, at a 21% reduction of the fee schedule. Emergency room services also will be reduced but procedures performed in ambulatory surgical centers will be exempted from the reduction.
- On the subject of bundling, 1,041 codes have been grouped into 255 umbrella codes. Balance billing limits will be based on the limiting charge of the umbrella code, and carriers have now been instructed to inform beneficiaries that they do not have to pay any additional charges for procedures bundled into one of the umbrella codes.
- HCFA has made changes in the relative values for 170 codes, with large increases in some cardiac catheterization codes (93524, 93626, and 93527).
- Also, HCFA has issued clearer guidelines pertaining to payments for global services. Physicians may bill separately if postoperative care is outside the expertise of the original surgeon. For example, if a second physician is brought in who actually provides the postoperative care, the modifier 55 must be used for billing purposes.

More changes can be expected as HCFA continues to refine the RBRVS process. The Texas Medical Association has been instrumental in many of these refinements and is pushing for updated geographic practice cost information that could result in better payment for Texas physicians.

Jim Bob Brame, MD
Box Y
Eldorado, TX 76936

Editor's note: *Dr Brame, a former president of Texas Medical Association, served two 3-year terms on the Physician Payment Review Commission, which advises Congress about Medicare payment issues.*

The tactics *are* the crime

A TERRIBLE INJUSTICE OCCURRED June 2, 1992, in Richardson, Tex. A large group of zealots, hiding behind the mask of religion, terrorized a physician who had done nothing unlawful or unethical. His crime, according to them, was his belief that women everywhere have the right to choose for themselves whether abortion is just.

The point of this letter is not whether abortion is right or wrong, because that issue will not be resolved for a long time. My concern lies with the tactics used by the anti-abortionists to express their beliefs.

While I believe the anti-abortionists have a right to their opinions and beliefs as do I and every other American, they are stretching their rights by unjust tactics. They use the local media along with pamphlets and signs reading "baby killer" and "murderer" to enhance their smear campaign. They harass not only the physician at work, but also his wife, family, neighbors, patients, and friends.

The result is that instead of being credited for his years of good, ethical, caring medicine, the physician is blemished by the twisted untruths spread against him. He feels alone and isolated. He receives many phone calls from patients who quickly forget his outstanding qualities and devotion to their health care and choose, rather, to chastise him for his belief in a woman's right to choose. The physician, feeling he has no choice, gives up performing abortions.

The fanatical zealots win! They are then fueled to catapult their next campaign onto the next isolated physician, always choosing one at a time, in a domino-like fashion.

And, sadly, the physician's fellow gynecologists, the majority of whom are pro-choice and many of whom also perform abortions, distance themselves so they will not be the next target. But if physicians stood with each other on this issue rather

than allowing one of their ranks to be singled out, these extreme tactics would not succeed.

Unless we take a stand against the anti-abortionists' tactics, eventually — despite a constitutional right to abortion — there will no longer be a choice, as no physician will be willing to make the sacrifice. Once these terrorists succeed in eliminating legal abortions it will be interesting to see what their next target will be. Is the end of democracy the final goal?

Alan M. Greenberg, MD
375 Municipal Dr, #218
Richardson, TX 75080

When are tongue depressors regulated waste?

THE RECENT ARTICLE, "JULY 6 deadline for compliance with all provisions of OSHA regs," (*Texas Medicine*, July 1992, pp 30–33) states that tongue depressors, exam table covers, and thermometer sheaths are regulated waste. This is an unfortunate misinterpretation of OSHA guidelines.

The definition of regulated waste is correctly stated in the article in the first column on p 32. While it is true that tongue depressors and the other items mentioned may become "contaminated" with potentially infectious materials, even mere contamination does not automatically assign these articles to the category of regulated waste unless they fulfill the definition's requirements of being able to release blood or other potentially infectious materials. Tongue depressors and the like, even if contaminated with a small amount of blood, pose no more of an infectious risk or public health problem than would a Band-Aid with blood on it from home. These items can go to a sanitary landfill regardless of their source and this is recognized by OSHA, the Centers for Disease Control, and the current laws regarding disposal of medical waste in Texas.

Physicians' offices and other health-care related facilities are already having difficulty deciding how to handle the waste streams from their facilities. Information such as provided in this article serves no one other than the owners of medical waste transport companies who are more than happy to have us throw every scrap of paper, facial tissue, and trash into their regulated medical waste containers. Correctly interpreted, the guidelines and regulations are quite reasonable. I think that a statement of correction is in order.

Farley Verner, MD
Waco Infectious Disease Associates, PA
2911 Herring, Suite 203
Waco, TX 76708

IN RESPONSE

DR VERNER'S STATEMENT THAT items such as tongue depressors, exam table covers, and thermometer sheaths are not automatically assigned into the category of regulated waste unless they fulfill the definitional requirements of the OSHA bloodborne pathogen standard is correct. For purposes of the OSHA standard, regulated waste means "liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials" (29 CFR §1910.1030[b]). The reference to tongue depressors, exam table covers, and thermometer sheaths in the article in *Texas Medicine* was made to heighten the awareness of physicians that normally innocuous articles, such as tongue depressors, can be considered regulated waste under certain conditions. We did not intend to imply that these items would always be considered regulated waste without regard to the nature and extent of the contamination.

It should also be noted that every item that falls within the definition of regulated waste in the OSHA bloodborne pathogen standard is not necessarily regulated medical waste ("special waste from health care related facilities" or "SWFHCRF") for purposes of the disposal regulations promulgated by the Texas Department of Health. For example, a cotton ball saturated with and dripping blood may not contain a sufficient volume of blood to be considered SWFHCRF, but it would be considered regulated waste for purposes of the OSHA bloodborne pathogen standard. Consequently, the cotton ball would need to be disposed of at the workplace in a regulated waste container meeting the requirements of the OSHA bloodborne pathogen standard, but the ultimate disposal of the cotton ball would not need to comply with the regulations for the disposal of SWFHCRF promulgated by the Texas Department of Health.

Jane Matheson, JD
Kathryn A. Christmann, JD
Hughes & Luce, LLP, Austin, Tex

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Upfront

US and Texas health-care reform to lead TMA conference

HEALTH CARE HAS MOVED to the front burner for both state and federal legislative bodies this year and speakers at Texas Medical Association's Fall Leadership Conference will present an insider's view of the issues.

US Rep J.J. "Jake" Pickle (D-Texas), state Sen Chet Brooks (D-Pasadena), and state Rep Jack Vowell (R-El Paso) are among legislative experts who will speak at the conference, Saturday, September 19, at the Stouffer Austin Hotel.

Other featured speakers include John L. Clowe, MD, Schenectady, NY, president of the American Medical Association, and M. Roy Schwarz, MD, Chicago, AMA senior vice president of medical education and science.

Dr Clowe, a family practitioner who was speaker of the AMA House of Delegates for 4 years, will explain why physician leadership is so vital to directing change while managing quality. Dr Schwarz will discuss the facts — and fears — surrounding HIV and physicians' practices. He also will participate in a panel about family violence. See "Start the healing now: What you can do about family violence," next page.

Fall LEADERSHIP CONFERENCE SEPTEMBER 19 1992 AUSTIN

Representative Pickle, chair of the House Ways and Means Subcommittee on Oversight, will discuss pending health-care legislation on Capitol Hill. Senator Chet Brooks, chair of the Senate Health and Human Services Committee, will moderate a panel on medical and health issues expected during the next Texas legislative session. Also on the panel, which will focus on the Texas Health Policy Task Force and sunset review of the Medical Practice Act, will be Representative Vowell; one additional panelist is pending.

Clockwise, from upper left, Rep J.J. "Jake" Pickle; John L. Clowe, MD; M. Roy Schwarz, MD; and Paul Burka.

The featured speakers and panel are scheduled during the conference's general session, 9:30 am to 12:30 pm.

Paul Burka, executive editor of *Texas Monthly* and author of the popular "Texas' Ten Best and Ten Worst Legislators" for that publication, will speak at the conference luncheon, which is hosted by Texas Medical Liability Trust. Mr Burka's topic is "The '92 Elections, the '93 Legislature, and Other Frightening Thoughts."

Following the luncheon, participants may attend either the panel on family violence or a risk management workshop from 2 to 5 pm. The risk management session, "From Deposition to Court Room," with James B. Edwards, JD, of Edwards & Calvert in Houston, costs $75 for TMA members and $125 for nonmembers. This workshop may be supplemented with a 12-hour independent study program designed to qualify physicians for a discount from liability insurance carriers under House Bill 18. The cost of the complete 15-hour program is $185 for TMA members and $285 for nonmembers. There is no charge for the family violence session.

In a free "Dawn Duster" session at 7:45 am, Dallas-based medical payment consultant Harold Whittington will present ways to reduce hassles brought on by Medicare's resource-based relative value scale.

Most of the association's

boards, councils, and committees also will meet during the conference weekend.

Although not required for the general session and dawn duster, conference preregistration is suggested. For further information, contact Jon R. Hornaday, director, TMA Special Services, (800) 880-1300 or (512) 370-1346. To register for the risk management program, contact Kathleen Threadgill, TMA office of risk management, (800) 880-1300 or (512) 370-1411.

Texas physician named AMA president-elect

JOSEPH T. PAINTER, MD, Houston, was chosen American Medical Association president-elect by AMA delegates meeting in Chicago in June. He will become president of the AMA in 1993.

A nationally recognized authority on cancer control, Dr Painter is an internist and oncologist at The University of Texas M.D. Anderson Cancer Center where he serves as vice president for health policy.

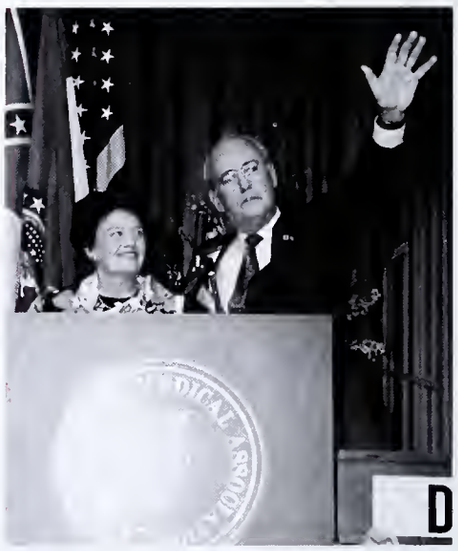
Following 13 years of service in the AMA House of Delegates, Dr Painter was first elected to the AMA board of trustees in 1984. He became its chairman in 1990. He is a former member of the Texas Medical Association board of trustees and served as TMA secretary during 1984–1986.

Described by his colleagues as a "determined advocate of American medicine and quality patient care," Dr Painter has stressed openness, availability of information, and team building within the AMA.

He is a delegate to the World Medical Association, former president and board member of the American Society of Internal Medicine, and former AMA commissioner to the Joint Commission on Accreditation of Healthcare Organizations.

A diplomate of the American Board of Internal Medicine, Dr Painter also is a fellow of the American College of Physicians.

An Austin native, he graduated from The University of Texas Medical Branch at Galveston in 1949. He is married to the former Ann Blanton Hill; they have four children — Joe, Sally, Martha, and Elizabeth.



Dr and Mrs Joseph T. Painter greet delegates at the AMA Annual Meeting.

Start the healing now: What you can do about family violence

THE FAMILY VIOLENCE PANEL session scheduled during the TMA Fall Conference has a lofty goal: dispelling myths about family violence and giving physicians some concrete advice about addressing the problem.

Among the myths are: "It doesn't happen to my patients"; "I can't detect it or prevent it"; and "If I try to intervene, I will become embroiled in legal action."

Addressing physicians' doubts and questions about family violence will be a group of panelists, including M. Roy Schwarz, MD, Chicago, AMA senior vice president of medical education and science; Diana Fite, MD, chair of the Harris County Medical Society's violence prevention program; a representative from the Texas Council on Family Violence; and one or more panelists who will address the legal and law enforcement aspects of the problem.

Initiated by the TMA Council on Communication in response to the association's support of the American Medical Association's major effort on family violence, the session will include information about specific laws relating to family violence and the legal responsibilities and liabilities of physicians treating victims.

Also included will be data on the extent of the problem in Texas, clinical guidelines on how to question and work with patients about family violence, and resource materials for both physicians and patients.

Among the resource materials available will be a physician brochure prepared jointly by the TMA Council on Public Health and the Texas Council on Family Violence. The brochure is scheduled to be mailed to about 10,000 primary care physicians in Texas at the end of September.

Texas delegation meets with success

THE TEXAS DELEGATION to the American Medical Association successfully carried 18 resolutions to the AMA House of Delegates at its annual meeting in June. Four other resolutions were referred to the AMA board of trustees for consideration. (See the August issue of *Action* for a review of the Texas resolutions.)

In other policy matters, the AMA House called for government action to provide formal physician organization involvement in public and private health-care policy and implementation, including changes in antitrust laws. Also approved was a Texas Delegation amendment that the AMA not endorse or advocate price-fixing in any form or budget predictability achieved by expenditure targets, budget caps, or global budget limits.

In other actions, AMA delegates outlined actions to address inequities in physician payment reform; opposed release of practice parameters or guidelines to the public before AMA and other relevant physician organizations review and comment on them; and called for AMA to assure strict confidentiality of information on individual physicians and patients in development and use of Uniform Clinical Data Set (UCDS) profiling information planned by PROs.

The AMA House honed AMA policy on HIV-related issues; spoke out on the alarming rise in tuberculosis in the country; and asked that AMA's efforts to stop family violence be an action item at each AMA annual meeting, also calling for a study on the impact of drugs and alcohol on family violence.

Pictured above, from left, members of the Texas Delegation to the American Medical Association R.A.D. Morton, MD, El Paso; James Roback, MD, College Station; Hugh Lamensdorf, MD, Fort Worth; and George Smith, MD, Marlin, discuss resolutions considered by the AMA House of Delegates during its annual meeting in June.

Nancy W. Dickey, MD, Richmond, was elected to a second 3-year term on the AMA Board of Trustees.

Robert P. Carroll, Jr, MD, Nacogdoches, was elected member-at-large of the American Medical Association Hospital Medical Staff Section governing council. He also chairs TMA's HMSS.

AMA Auxiliary changes to Alliance

CLOSE ON THE HEELS OF Texas Medical Association Auxiliary's name change in May to the TMA Alliance, the nearly 300-member House of Delegates of the American Medical Association Auxiliary voted in June to change its name to the AMA Alliance. The change will become official next June.

The name change, coupled with a new slogan, "Physicians' spouses dedicated to the health of America," resulted from a lengthy study that explored perceptions of the name and the image the organization wishes to project. Voting by secret ballot during the 70th annual convention, delegates approved the change by a two-to-one margin.

Also at the AMAA convention, two Texans assumed leadership positions. Mary Lynn Smith, Athens, TMAA president in 1986–1987, was installed as AMAA recording secretary. Dixie Louis, Dickinson, TMAA president in 1988–1989, began a year on the AMAA long-range planning committee. Cyndy Hudgins,

Dallas, immediate past TMAA president, served on the reference committee that heard testimony concerning the name change.

They broke the mold . . .

ALMOST EVERYONE KNOWS at least one person who goes at life with flair. *Texas Medicine* plans a series of profiles of fascinating Texas physicians and medical students and would like your help in choosing the subjects of the series.

While a physician's professional achievements certainly are one measure of his or her worth, we do not plan to limit the series to those who have achieved the most in this one area. Rather, physicians and medical students who are particularly fascinating people — perhaps because of their lifestyles, hobbies, histories, families, or accomplishments — will be considered for the series.

If you know someone (yourself?) who would make a good focus for an article, please let us know.

Please call or write Kathryn Trombatore, managing editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701, (800) 880-1300 or (512) 370-1380. ★

How many degrees do you have?

WAS ONE PROFESSIONAL DEGREE just not enough for you? If you are a Texas physician with more than an MD after your name, *Texas Medicine* would like to hear from you.

We plan an article about physicians with multiple degrees, such as PhD, DVM, MBA, or JD, and would like to know about your experiences.

What made you go for that extra education? Has it made a difference in your career? Or did you pursue the education for non-career reasons? Has having more than one degree affected your income? Have you considered changing professions as a result of the additional degree? Did you get your medical degree first?

If you'd like to be considered for the article or know someone who should be, please call or write Kathryn Trombatore, managing editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701, (800) 880-1300 or (512) 370-1380.

TMA goes high tech for OSHA program

TEXAS MEDICAL Association made its debut into telemedicine July 15 — and by all accounts the program was a success. Produced in cooperation with Texas Tech's MEDNET service, the panel presentation was organized by TMA to inform physicians and health-care professionals on the new bloodborne pathogens standards requirement from the Occupational Safety and Health Administration.

From Tech's studio, the live, interactive continuing medical education program was beamed over satellite to 48 hospital sites. The last 15 minutes of the hour-and-a-half program allowed viewers to ask the experts questions.

Presenters (seated in the photograph) included Jane Matheson, JD, an Austin attorney specializing in administrative actions under OSHA and consultant on workplace safety and health issues; Barry Hafkin, MD, an infectious disease specialist from Austin and chair of TMA's Committee on Continuing Education; and Nancy Bethea, PhD, the supervisory industrial hygienist for the Lubbock area office of OSHA. TMA and MEDNET staff are shown preparing for the presentation.

CASE HISTORY

From the Files of ICA

CASE SUMMARY

A 60-year-old man with a history of diabetes and heart disease was admitted to ICU with a 30 percent third-degree burn. At 5:00 P.M. a nurse called the surgeon stating that the patient had vomited "coffee ground" material.

The surgeon passed an N.G. tube, and after irrigation he decided that no active bleeding was occurring. A stat blood count revealed a Hb and Hct slightly lower than the previous day, but still above 10 grams and 30 percent respectively. The doctor ordered a repeat Hb and Hct for 10:00 P.M. and requested the patient's blood be typed and cross matched. He then went home.

At 1:00 A.M. a nurse called the doctor to inform him, "The patient is still bleeding from the nasogastric tube and is shocky." The patient arrested before the doctor ever reached the hospital and died in spite of resuscitative efforts.

On reviewing the nurse's notes, the doctor discovered the nurse on duty at 5:00 P.M. recorded that the patient was actively bleeding and continued to bleed after he had left the hospital. This observation was contrary to his own progress notes at the time.

1. From a medical standpoint, how would you have handled this case differently?
2. How would you deal with the nurse's notes?
3. How would you deal with the nurse?
4. How would you address the incorrect note in the chart? Your own note? That of another party?
5. Assume the patient did not die, how would you then handle such a nurse's note?

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People

NEWSMAKERS

J. Michael Badgwell, MD, associate professor of anesthesiology and pediatrics at Texas Tech University Health Sciences Center, was chosen executive committee chairperson-elect of the American Academy of Pediatrics Section on Anesthesiology.

The Deep East Texas Council of Governments honored Trinity family practitioner **Sam Barnes, MD,** with the 1992 Ralph W. Steen East Texan of the Year Award for 45 years of community service.

Houston general surgeon **Walter J. Burdette, MD,** received the Distinguished Alumni Award from Yale University.

Joseph N. Corriere, Jr, MD, was appointed the first holder of the Dr Cecil M. Crigler chair in urology at The University of Texas Medical School in Houston.

The American Diabetes Association has chosen Houston endocrinologist **Alan J. Garber, MD,** to serve on its national board of directors.

Alan R. Hull, MD, founder of Dallas Nephrology Associates and current chair of the National Kidney Foundation's Public Policy Committee, has been selected president of the American Society of Transplant Physicians. Dr Hull also serves as president of The Renal Physicians of Texas, as an originating board member of Southwest Organ Bank, and as clinical professor of internal medicine at The University of Texas Southwestern Medical Center at Dallas.

Clifford F. Mountain, MD, professor of thoracic surgery at The University of Texas M.D. Anderson Cancer Center, received the 1992 Distinguished Alumnus Award from Boston University School of Medicine. Dr Mountain is known worldwide for his expertise in the application of statistical methods in biomedical research. As an original member and first president of the International Association for the Study of Lung Cancer, he also helped launch the first world conference on lung cancer.

Robert E. Neimes, MD, director of the San Antonio State Chest Hospital, has been elected vice president of the United States-Mexico Border Health Association. The purpose of the association is to resolve health problems along the common border of the two countries.

Sanger physician **Richard Perry, DO,** is a charter member of the newly organized American Medical Society for Sports Medicine.

Victor J. Weiss, Jr, MD, San Antonio, is president of the Titus Harris Society, an organization of psychiatrists who graduated from The University of Texas Medical Branch at Galveston.

Please let *Texas Medicine* know about your honors and achievements.

Criteria for inclusion in the Newsmakers section are: TMA member; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, Texas Medicine, *401 W 15th St, Austin, TX 78701.*

OBITUARIES

James Norton Burkeholder, MD, 65; Lubbock; University of Missouri-Columbia, 1961; died June 27, 1992.

James R. Doty, Jr, MD, 65; Richardson; Indiana University School of Medicine, 1956; died June 24, 1992.

Orlando Gonzalez, MD, 63; San Antonio; Havana University School of Medicine, 1953; died July 1, 1992.

Edward E. Kearns, MD, 64; Houston; Baylor College of Medicine, 1953; died June 12, 1992.

Leonard I. Koch, MD, 60; Lubbock; The University of Texas Medical Branch at Galveston, 1956; died June 25, 1992.

Melba L. McNeil-Moore, MD, 73; Edna; The University of Texas Southwestern Medical School, 1945; died June 14, 1992.

Adair W. White, Jr, MD, 67; College Station; Johns Hopkins University School of Medicine, 1947; died July 6, 1992.

Medical Economics

TMA battles problems at Workers' Comp Commission

FOLLOWING A PITCHED battle 4 years ago among the state's businesses, labor organizations, trial lawyers, and organized medicine, new legislation emerged to replace an antiquated system of dealing with workers' compensation injuries in Texas. But despite the changes, physicians say they are experiencing major problems with reimbursement and utilization review (UR) in the system.

The primary dilemma, physicians say, is in the area of fee disputes.

When physicians and insurers cannot agree over the level of reimbursement for a workers' compensation claim, either party may submit the disagreement to a medical dispute resolution process administered by Texas Workers' Compensation Commission (TWCC) designed to mediate such conflicts. (See sidebar.)

However, many physicians complain that the TWCC dispute resolution program is cumbersome, time-consuming, and ineffective. Physicians cite a backlog of unresolved cases and their inability to get information on the status of a case. In addition, they say the lack of appropriate regulation of the industry's UR system is forcing more and more cases into the dispute resolution process.

"It's a bureaucratic black hole," said Ray E. Santos, MD, chairman of TMA's Committee on Workers' Compensation and Occupational Medicine. "Cases are filed by physicians and then just seem to disappear. By our estimates, they have hundreds — perhaps even thousands — of unresolved cases that are now 30 months old or older in terms of when the doctor first saw the patient.

"It is a situation where 'justice delayed is justice denied' for these physicians," Dr Santos added. "The commission has made the review of medical fee disputes its lowest priority, so no wonder there is a crisis of confidence from the physician community. There are a number of instances in which physicians are simply leaving the program."

> "IT IS A SITUATION WHERE 'JUSTICE DELAYED IS JUSTICE DENIED' FOR THESE PHYSICIANS."

Members of TMA's Committee on Workers' Compensation and Occupational Medicine and several TMA staff members met with TWCC staff in July to discuss the problems. According to Dr Santos, the meeting was very constructive in analyzing the problems, but there was no agreement on solutions for the situation.

"The reimbursement level for most workers' compensation claims is low enough that, in many cases, a delay in getting the full amount due works out to a net loss for the providing physician," said David Marcus, PhD, TMA's director of health-care financing. He added that many cases appear to be lost in the system, with TWCC often unable to tell a physician where his or her claim is in the process or even if they have received it.

Officials with TWCC disagree, saying their backlog of cases goes back only 5 or 6 months, but they could not provide statistics showing the number of claims pending and the number handled during any given period. Julie Shank, RN, TWCC's director of medical review, said her goal is a 3- to 4-month turnaround on fee disputes, but that the agency has other, higher priorities.

"The fee disputes are literally last as far as priority, because the care that the injured worker needs, the preauthorization of spinal surgery, will always come first," she said, adding that despite having nine people (with recent authorization to hire two more) on the medical review staff, budget constraints by the legislature have made it difficult to keep up with the workload.

Many of the problems stem from reform legislation passed in 1989 when the workers' compensation system in the state was near collapse. Injuries occurring after January 1, 1990, fall under the new legislation, while injuries occurring in 1989 and earlier fall under the "old" law, dating back to 1913. The dispute resolution process was created in the 1989 legislation to replace the appeals process under the old Industrial Accident Board.

According to Dr Marcus, the use of unregulated fourth-party review companies by workers' compensation insurance providers to perform UR is a major factor in the number of claims ending up in dispute resolution.

"Frankly, what we have experienced with some of them has been outrageous behavior after outrageous behavior," he said, adding that while many of them are responsible auditors of medical bills, the absence of regulation by the Texas State Board of Medical Examiners has led to several abuses that have caused many of the fee

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

TWCC says correct form, information can speed dispute resolution

WHILE FILLING OUT FORMS and compiling documentation for the Workers' Compensation dispute resolution process can add to the cost — and certainly adds to the hassle — of collecting fees, there is no denying that correctly filed paperwork can speed up the bureaucratic process.

According to Julie Shank, RN, director of medical review for the Texas Workers' Compensation Commission (TWCC), incomplete or missing information on a claim is the most common reason a case is delayed.

"It takes a lot of staff time to deal with incomplete cases," she said. "In June, we looked at 300 disputes, and 120 of those had to go back for more information. If they send in all the information at the first point, then we can start handling it."

The TWCC dispute resolution process is designed to mediate between parties, most often physicians and insurance carriers, who disagree on medical charges and/or treatment.

According to TWCC regulations, requests submitted on injuries on or after January 1, 1991, may be filed between 60 days after the insurance carrier received the bill from the provider and no later than one calendar year from the date of service. Findings by the TWCC are binding.

Requests for dispute resolution must be filed in writing, and TWCC staff strongly suggest physicians use a TWCC-60 form, although requests may simply be filed in the form of a letter.

Physicians requesting dispute resolution must show that reasonable attempts were made to resolve the disagreement, including documentation of at least one phone call (notes including time, date, and name of carrier representative) and one letter to the carrier justifying the charges.

Other information TWCC says must be included in the request includes:

- a listing of the TWCC file number (if known); claimant's name, address, and Social Security number; carrier's name and address; and date of injury;
- explanation of the type of medical dispute (ie, medical necessity, fees, or compliance);
- summary of disputed issues;
- requesting party's position;
- amount of money disputed, amount billed to carrier, amount paid by carrier, and date of service;
- name and phone number of contact person for requesting party; and
- signature of requesting party.

The party in the dispute found to be in the wrong is assessed a $25-per-hour review fee. An additional fee is charged for peer review.

According to David Marcus, PhD, TMA's director of health-care financing, TWCC has shown a tendency to send back and delay any case that it decides does not contain complete information.

"Sometimes it seems like they are prepared to bounce something just because it has a comma out of place," he said. "We think that they are more than a little out of line sometimes in their pickiness."

Thus it is particularly important to send the request to TWCC's medical review division office in Austin, not to a field office or other division. Such requests are often misplaced or sit in mailrooms for weeks waiting to be rerouted or returned, Dr Marcus said.

Address requests and other correspondence to:

Medical Dispute Resolution
Medical Review Division
Texas Workers' Compensation Commission
4000 South IH-35, Suite 814
Austin, TX 78704-7491

The TWCC has published a pamphlet describing the process and the necessary information for a dispute resolution request. For a copy, write to the above address or call (512) 440-3591.

In addition, TMA has published a 60-page booklet, "Workers' Compensation: A Brief Guide for Texas Physicians," explaining the law and associated regulations. The booklet is $35 for TMA members, $70 for nonmembers. To order, contact TMA Practice Management Services at (800) 880-1300 or (512) 370-1422.

disputes now before the TWCC.

"We have had cases where they (fourth-party reviewers) have denied treatment to individuals who have reached the end of the 2-year period in which workers' comp claims must be settled, even though the insurance company remains liable indefinitely for any consequence of the injury that required medical treatment," he said. "We have also found firms that will not approve any kind of psychiatric treatment for depression in workers' compensation victims, even though it is common for injured people who are only improving very slowly or not at all to become very depressed about their situation."

Workers' compensation insurance carriers are regulated by the State Board of Insurance, even though the carriers' decisions may have the effect of specifying a specific treatment regimen.

Dr Marcus noted other problem areas, such as medical directors not licensed to practice in the state of Texas or medical directors who practice in a specialty that rarely deals with workers' compensation cases. A medical director not licensed in Texas or trained in any area of workers' compensation medicine is still in the position of sending out medical opinions about reviews of cases and setting treatment regimens, he said. Currently, Dr Marcus added, the Texas State Board of Medical Examiners does not consider UR the practice of medicine, although ordering alternative medical regimens for patients "certainly sounds a lot like practicing medicine."

The answer, he said, is for the TWCC to begin looking at the fourth-party reviewers and to use its power to bring them into line.

"These companies have acted outrageously because they have found that the commission will do nothing," Dr Marcus said. "They know that cases denied will simply end up in the dispute resolution process, and that's that. The problem will not be solved until the commission takes decisive action to deal with the problems."

> "THESE COMPANIES HAVE ACTED OUTRAGEOUSLY BECAUSE THEY HAVE FOUND THAT THE COMMISSION WILL DO NOTHING."

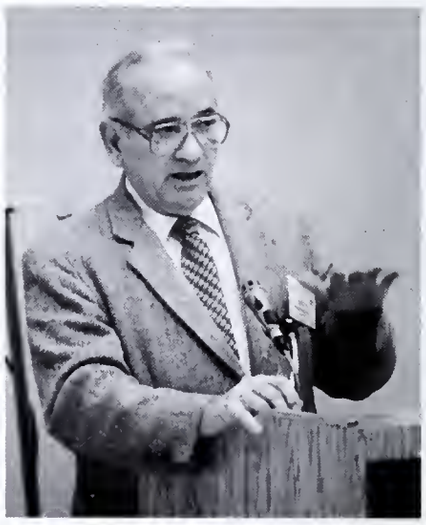
They have taken a small step in that direction, he said, noting that TWCC has recently published regulations allowing for audits of some fourth-party reviewers.

TMA's Committee on Workers' Compensation and Occupational Medicine and staff will continue to meet regularly with TWCC staff in an effort to work toward solutions to problems with the dispute resolution process and fourth-party review.

Donald L. Kelley, MD, retires as state Medicaid director

After a 5-year tenure during which he ushered in many major changes to an embattled program, Donald L. Kelley, MD, has retired from the Texas Department of Human Services (DHS) as director of the state's Medicaid program.

Dr Kelley will be replaced on an interim basis by Randy Washington, an 19-year DHS veteran, until a permanent director is named.



Donald L. Kelley, MD, retired as state Medicaid director at the end of July.

"We will miss him," said Fred Merian, MD, chairman of TMA's Council on Socioeconomics. "He's been a good friend of medicine and has seen the Medicaid program through a lot of changes. He has been a good man to work with."

According to Mike Dabbs, TMA director of quality assurance/utilization review, he was instrumental in getting several critical changes made in the Texas Medicaid program.

"Dr Kelley has always acted more like a physician than a bureaucrat," he said. "He has always come down on the side of providing more services when he has had the resources to do so. He has always been committed to issues such as access to care and physician reimbursement."

Under Dr Kelley, Medicaid has made changes in fee structures and other program aspects that have improved reimbursements and increased access to care.

In April of this year, the program adopted a relative value scale for payment of fees for physicians participating in the program. The scale boosts reimbursement levels for primary care services, allowing more

physicians to participate in the program and improving access to care for thousands of Texans.

Other Medicaid changes under Dr Kelley's leadership included boosting payments to primary care physicians by 40% in April 1991, restoring a 10% budget reduction from 1986 in September 1991 to add $18 million back into the budget, and increasing the reimbursement for early periodic screening, diagnosis, and treatment (EPSDT) from $27 to $40, making it possible for more mothers and young children to visit a physician.

The TMA Council on Socioeconomics honored Dr Kelley with a plaque at the 1991 Fall Leadership Conference for his work in increasing access to health care for Texans by improving Medicaid reimbursements to physicians.

According to Mr Dabbs, TMA is concerned that the position of Medicaid program director be filled by a physician.

"The job has always been filled by a physician and with good reason," he said. "It takes someone capable of assessing the health needs of the indigent population from a medical practice standpoint as well as a health policy standpoint."

He said that TMA has written Gov Ann Richards and DHS officials encouraging them to replace Dr Kelley with a qualified physician. DHS officials have set no timetable to name a replacement. Mr Washington said he was asked to serve in an interim capacity until September 1993, when Medicaid's Acute Care and Preventative Care programs are transferred from DHS to the Texas Department of Health as part of a legislatively mandated restructuring of the program. ★

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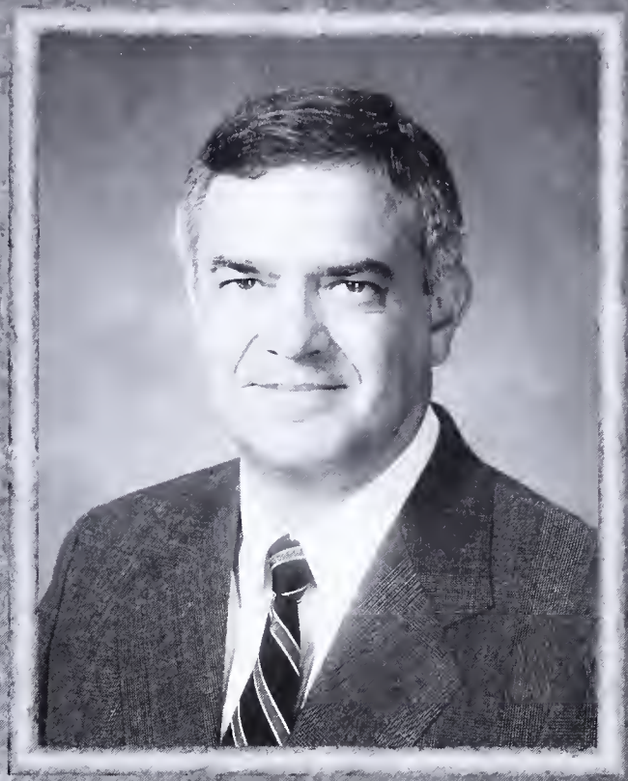

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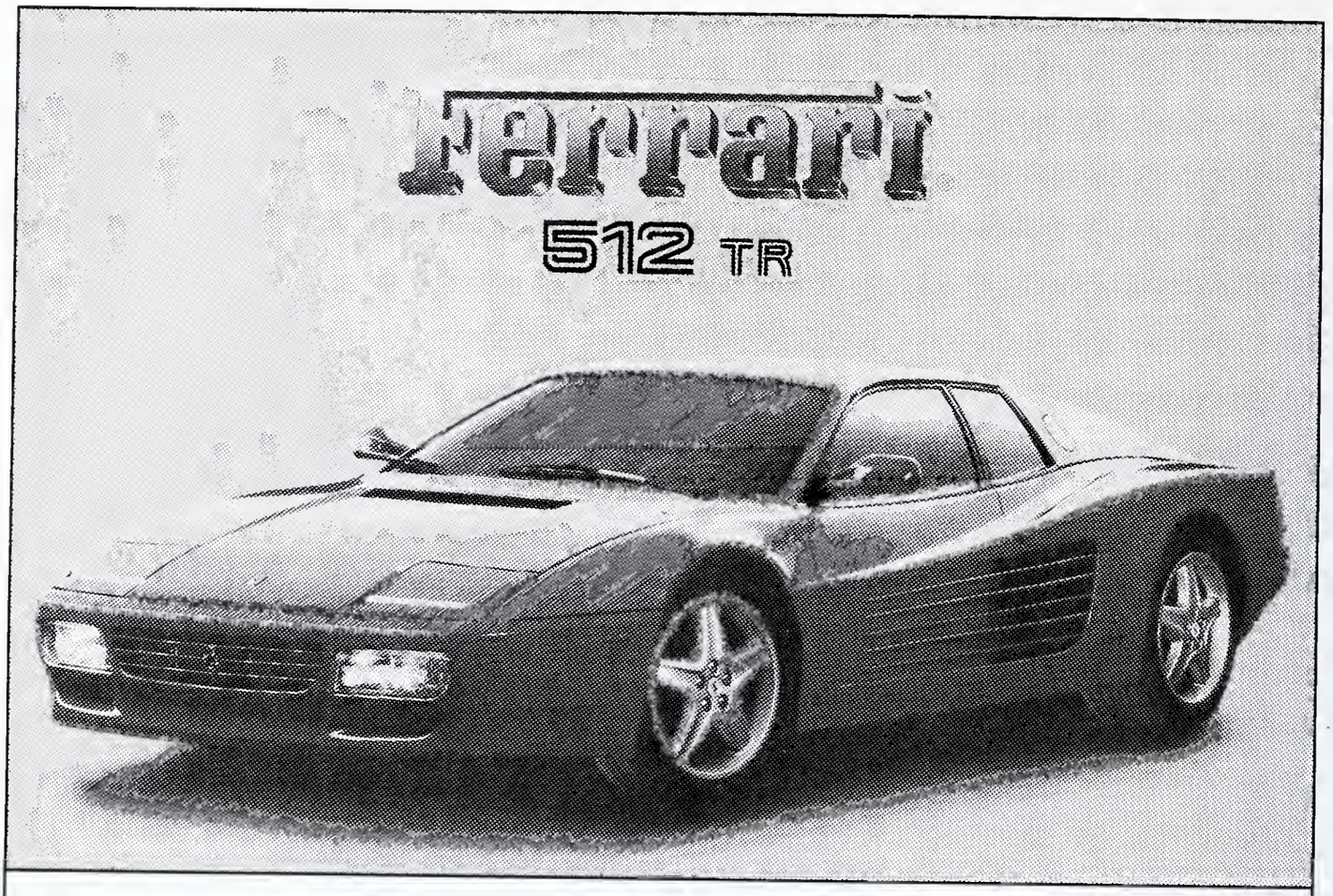

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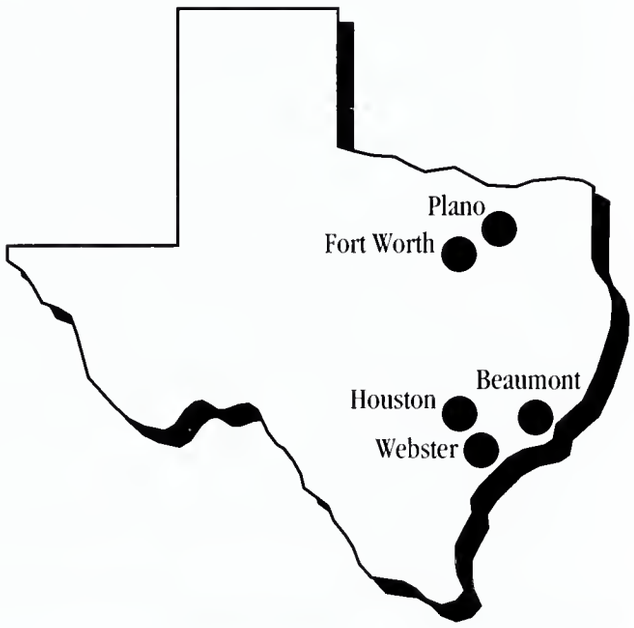

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Science and Education

Performance-based funding report goes to Coordinating Board

PROPOSING FUNDING CONCEPTS that will radically change the way the state's medical schools are financed, the Performance-Based Funding Committee for Health Related Institutions presented its report to the Texas Higher Education Coordinating Board in July.

The committee, with research assistance from the Texas Medical Association, developed formulas to measure the performance of medical schools and other health-related institutions beginning in fiscal year 1993. The committee was charged with developing the performance standards by the Texas Legislature. Performance-based funding (PBF) is a concept by which funding for agencies, institutions, and programs is based on a predetermined set of criteria. Those criteria will require institutions or programs to meet standards in order to retain or increase their budgets in subsequent years.

The committee was chaired by Kern Wildenthal, MD, PhD, president of The University of Texas Southwestern Medical Center in Dallas, who in a letter to Coordinating Board Chairman Kenneth Ashworth, PhD, said the committee worked hard to achieve balance and fairness in developing the funding formulas.

"The committee believes that these recommendations represent the best basis for allocating funds to Texas' health-related institutions according to their performance in those areas in which they share common missions and goals," he said.

The state's six health science centers are:

- Texas A&M University Health Science Center in College Station;
- Texas Tech University Health Sciences Center in Lubbock with Regional Academic Health Centers in Amarillo, El Paso, and Odessa;
- The University of Texas Health Science Center in Houston (UTHSC-H);
- The University of Texas Health Science Center in San Antonio;
- The University of Texas Medical Branch in Galveston (UTMB); and
- The University of Texas Southwestern Medical Center in Dallas.

"The committee believes that these recommendations represent the best basis for allocating funds to Texas' health-related institutions . . ."

The Texas College of Osteopathic Medicine in Fort Worth is a public medical school affiliated with the University of North Texas. In addition, Baylor College of Medicine in Houston, the only private medical school in the state, receives state funding for medical student education based on calculations of the average cost for medical student education at UTHSC-H and UTMB.

The PBF committee determined the common missions of the state's academic health science centers as:

- education for degree- and certificate-seeking students and postgraduate students (residents and fellows);
- continuing education for health professionals;
- biomedical and health-related research;
- clinical care for indigent and referred fee-for-service patients; and
- community service, including economic development, the administration of special health programs, and shared clinical, health management, research, and educational expertise.

Based on its analysis, the committee determined that the basis for distributing funding among the various missions at the health science centers should be:

• Education	80.0%
• Research/ Training	7.5%
• Patient Care	12.5%

The formula for funding the medical school components of the state's six health science centers is based on primary goals developed for admissions, graduation, and licensure, with so-called "bonus" measures developed for several other factors. Each bonus measure is assigned a percentage, which is the amount of funding increase an institution may attain if that goal is met. The legislature then sets the amount of funding based on the formula.

The bonus measures for medical schools include attaining minority recruitment goals (+15%); first-try pass on parts 1 and 2 of license exams (+10%); number of graduates entering family practice specialties (+20%); number of graduates entering internal medicine, pediatrics, obstetrics, or emergency medicine spe-

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

Hypothermia studied as brain injury treatment

The University of Texas Medical School, Houston — Research physicians are studying the use of hypothermia as a treatment for severe brain injury and as a method to lessen long-term neurologic problems. Guy L. Clifton, MD, professor and director of neurosurgery, said that until recently no randomized testing of hypothermia had been done on brain-injured patients, but a team of physicians working at Hermann and Lyndon B. Johnson hospitals in Houston have begun a study. In the program, trauma patients with a severe brain injury — included in the study with the permission of their families — are being cooled to 33.3°C with cooling blankets during treatment and are given psychological and physical tests at 3-, 6- and 12-month intervals after treatment. The project will continue for 2 more years.

Tiny implants appear to regenerate damaged cartilage

The University of Texas Health Science Center, San Antonio — Scientists using tiny, biodegradable implants have successfully regenerated cartilage in lab animals, and the healing method may have practical applications for sports injuries in humans. Researchers say the implants carry growth factors within a dissolvable shell. As the shell breaks down, the growth factors seep into the surrounding cartilage. The objective of the research, according to Kyriacos Athanasiou, PhD, assistant professor of orthopedics and director of the orthopedics biomechanics lab, is to make the cartilage repair itself without leaving a prosthesis in the body. The implant may also have uses in the treatment of osteoarthritis, he said. The 2-year study is supported by a grant from the state of Texas.

Trials show high-dose vitamin E may slow atherosclerosis

The University of Texas Southwestern Medical Center, Dallas — Researchers have shown in clinical studies that megadoses of vitamin E may slow the development of atherosclerosis. When volunteers were given daily doses of 800 IUs of alpha-tocopherol (vitamin E), researchers discovered that the oxidation rate of low-density lipoprotein was reduced by half. During the study, two groups of 12 normal men were given either a placebo or vitamin E for 12 weeks, and the levels of vitamin E and lipids were measured in the beginning and at 6 and 12 weeks. Ishwarlal Jialal, MD, associate professor of internal medicine, and Scott Grundy, MD, director of Southwestern's Center for Human Nutrition, published their finding in the June issue of *Journal of Lipid Research*.

Baylor establishes Center for Pain Medicine

Baylor College of Medicine, Houston — The Baylor Center for Pain Medicine opened its doors in July to treat patients suffering from persistent pain. The center offers chronic pain management programs involving a combination of invasive procedures, biofeedback, psychological counseling, physical therapy, rehabilitation, and other techniques. According to Alexander M. Straja, MD, the center's medical director, chronic pain accounts for more than $50 billion in medical costs and lost wages each year, making it one of the country's most expensive and disabling disorders. Dr Straja said a "team approach" to pain management will benefit patients with low back pain, migraine headache, reflex sympathetic dystrophy, and other pain-related problems.

Information for this column comes from a variety of sources, including academic institutions, state and federal agencies, and private institutions. We welcome submission of items of interest. Send them to Texas Medicine, *Science and Education Editor, 401 W 15th St, Austin, TX 78701.*

cialties (+10%); and the number and type of graduates who practice in federally designated health professional shortage areas (+20%).

Similar formulas were developed for other allied health institutions such as dental, nursing, and other schools.

Each institution's primary goals are given weighted values, and that along with bonus measures add up to the total funding package for the school. It is then up to the Texas Legislature to determine the level of funding.

James Rohack, MD, chairman of TMA's Council on Medical Education, said the PBF formulas contained in the committee report are about what he expected to see, but he still has reservations about some aspects of them.

"In some cases, it's not really fair to the schools to hold them responsible for their graduates' actions," he said, noting that certain parts of the funding formulas are related to students' choice of specialty and practice locations. "That's like what the NCAA does to a basketball program. A coach may have committed a recruiting violation 5 years ago, but they penalize this year's team.

"We need to promote more physicians going into family practice and going into manpower shortage areas, but this may not be the way to go about it," he said.

Dr Rohack added that there is some concern as to how the legislature will use the "bonus" measures attached to the funding formula.

"We're concerned that they will fund the schools' core curriculum at a low level, say 60% or 70%, and use the bonus measures to make them 'earn' the rest," he said. "We feel the medical school's core curriculum should be funded at or close to 100%, with the ability to obtain

additional funding through achieving the additional goals."

Some competition among the state's medical schools is generally good, Dr Rohack said, but too much could ultimately be harmful to the state.

"A medical education from one school in Texas should be of equal high quality to that of any other school's degree," he said. "If we reach a point where one school's degree is seen as more valuable or better than another's, that harms all our schools. And there's some possibility in this program for that to happen. We need to be careful how we structure this."

Both Drs Wildenthal and Rohack called for state officials to phase the PBF system over a period of time to avoid disproportionate changes in funding to individual institutions.

TMA plans to remain active in monitoring the way lawmakers implement the plan during the next legislative session in 1993, Dr Rohack said.

Conference to discuss animal research issues

THE DEBATE SURROUNDING the use of laboratory animals for biomedical research is often emotional, but physicians can arm themselves with the facts by attending an American Medical Association conference on animal research September 25 in San Antonio.

The one-day workshop, cosponsored by The University of Texas Health Science Center in San Antonio (UTHSC-SA), the Texas Society for Biomedical Research (TSBR), and the Texas Medical Association, is designed to help physicians, scientists, and medical and graduate students understand the facts regarding the use of animals in medical research.

"This session is designed to build grass roots support for the use of animals in research via physicians, researchers, and students — individuals viewed by Americans as trusted and balanced sources of medical and scientific information," said Karen A. Gorrell, project manager with AMA's science and technology section. "Conference participants will have ample time to talk with targeted researchers and leading authorities."

J. Kent Trinkle, MD, professor and head of cardiovascular surgery at UTHSC-SA, will be the guest speaker. The AMA has designated the conference as meeting the criteria for 6 credit hours in Category 1 of the Physician's Recognition Award.

The workshop is scheduled from 9 am to 3 pm on Friday, September 25, at the UTHSC-SA Auditorium, 7703 Floyd Curl Dr, San Antonio. Registration is free to medical and graduate students and residents; $25 for AMA, TMA, or TSBR members; and $35 for nonmembers. The fee includes a continental breakfast, lunch, and a comprehensive resource kit that includes a video, speeches, a scripted slide show, sample letters, and more.

In addition, TSBR will sponsor a reception on Thursday night, September 24, at UTHSC-SA for workshop participants.

To register, call the AMA at (312) 464-4574. As a security measure, all participants will need proof of identification and affiliation at the workshop.

Most loan provisions intact in Higher Education Act

THANKS TO SOME HARD work by physicians and medical students from around the country, including a large number from Texas, several key facets of the federal Title IV student loan program have been preserved despite attempts by some in Congress to make medical students pay back their college loans much sooner than now required.

A House/Senate conference committee report on the federal Higher Education Act reauthorization bill, which includes several enhancements to medical student loan provisions, was approved by both houses and signed by the president in mid-July.

The final version of the bill contains several enhancements to the loan program sought by organized medicine, including TMA and the AMA. These enhancements include provisions regarding loan deferment, forbearance, and accreditation.

"These are the changes we were looking for in the bill," said James Rohack, MD, chairman of TMA's Council on Medical Education. "There is one caveat, however. We are going to watch closely to see how the new rules for student loans are written by the Department of Education. We want to make sure they follow the wishes of Congress."

"We are going to watch closely to see how the new rules for student loans are written . . ."

Major features of the student loan provisions of the bill are:

- Deferment: Congress adopted language including provisions to extend deferment of student loans to 3 years for medical residents who meet the definition of economic hardship, which will be defined later in regulations. No interest accrues on a loan during a period of deferment.
- Forbearance: The bill adopts language including provisions retaining and improving the ability to forbear loans. The forbearance adopted is defined as a temporary cessation of payment, unless the borrower opts for an extension of time or smaller payments. Interest accrues on a loan during a period of forbearance.
- Foreign Medical Schools: The bill adopted language providing that

students attending schools outside the United States will continue to be eligible for student loans.

The bill includes language instructing the Secretary of Education to consider a borrower's debt-to-income ratio in defining economic hardship. The bill also provides that deferment for those residents who obtain loans prior to July 1, 1993, will continue. Medical students will still have 10 years in which to repay their loans.

The bill also includes a provision preserving the structure and operation of the Liaison Committee on Medical Education (LCME) and the Committee on Allied Health Education and Accreditation without imposing administrative and financial separation requirements.

TMA was very active in supporting the changes in the student loan provisions of the bill, according to Lawanda Hartman, TMA director of medical education.

"The Council on Medical Education began writing letters to Congress about this late last year," she said. "We also got our student chapters involved in letter writing and made other contacts with Congress about this bill."

The AMA credited a massive letter, telephone call, and personal contacts campaign with turning the tide for the student loan provisions of the bill, saying that the effort was "crucial" in obtaining a favorable result.

The next step in the process will be the drafting of regulations to implement the bill by the Department of Education. The draft regulations will be published in the *Federal Register* for public comment. The regulations are expected out by sometime this fall.

Researcher gets NIH grant for Human Genome Project research

A RESEARCH SCIENTIST AT The University of Texas Health Science Center in San Antonio has received a 5-year, $7.7 million grant from the National Institutes of Health (NIH) to study a chromosome believed to be a key to certain cancers.

Susan Naylor, PhD, professor of cellular and structural biology at UTHSC-SA, is a recognized international authority on the genetic structure of human chromosomes. She is one of more than a dozen Texas-based researchers participating in the Human Genome Project, the ambitious worldwide effort to map the structure of human genetics. Some 20 grants totaling about $20 million have been awarded to researchers in Texas as part of the Human Genome Project, according to the NIH.

According to UTHSC-SA President John P. Howe III, MD, the $7.7 million grant is the institution's largest 5-year award ever.

Dr Naylor will lead a study of chromosome 3, the third largest of the 23 pairs of human chromosomes. Chromosome 3 has been linked to lung, breast, ovarian, testicular, and renal cancers, and retinitis pigmentosa. She believes that chromosome 3 plays a key role in "small cell" lung cancer.

"Chromosome 3 is damaged in every case of small-cell cancer we study," Dr Naylor said. "We know a defect on the chromosome is very primary to cancer."

Other Texas institutions participating in the Human Genome Project are Baylor College of Medicine in Houston, The University of Texas Southwestern Medical Center in Dallas, The University of Texas M.D. Anderson Cancer Center, The University of Texas Health Science Center in Houston, the University of Houston, the Southwest Foundation for Biomedical Research in San Antonio, and several other private research foundations. ★

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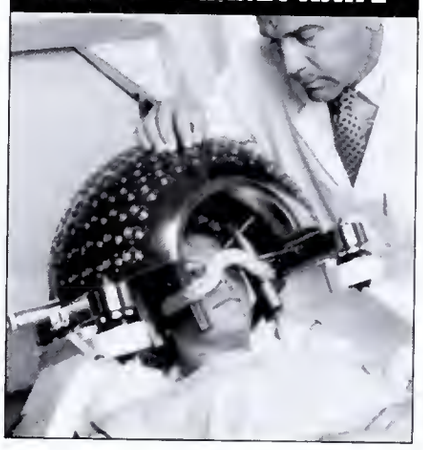

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Legislative Affairs

Task force receives medical liability report

A REPORT ON MEDICAL liability jointly funded by Texas Medical Association, Texas Hospital Association, and Texas Trial Lawyers Association has been presented to the Texas Health Policy Task Force. The three organizations that financed the project, however, said its findings are too preliminary to identify specific recommendations for solving tort problems in Texas.

"Because of limitations on the data collected and questions not addressed by the study, our three organizations concur that some conclusions and solutions regarding physician and hospital professional liability are premature," the groups said in a joint statement delivered to the task force on July 29.

The report, prepared by Austin consulting firm Tonn and Associates, found that medical liability premiums and indemnity payments account for less than 1% of overall health-care spending in Texas.

"It did not surprise us that the study put medical liability costs as a relatively small percentage of the total health-care dollar, since physician services are similarly only a fraction of the total cost of health care," said TMA President William G. Gamel, MD, Austin.

"However, the cost of medical liability inside physician services can be serious, depending on the kind of medical care and where it is located," Dr Gamel added. "Some areas of our state look like a lawsuit war zone, and some specialized areas of care, such as obstetrics, literally are being sued into nonexistence."

> "SOME AREAS OF OUR STATE LOOK LIKE A LAWSUIT WAR ZONE..."

In their joint statement, TMA, THA, and TTLA pointed out that the report raises a number of unanswered questions, including the impact of medical liability on access to care, the impact of large judgments or high frequencies of suits on individual physicians and hospitals, and measurable costs of defensive medicine.

Dr Gamel called the report the "first tentative step" in addressing tort problems, but he added that more research is needed.

"The report is a good start and establishes a basis for further discussions," the groups said in their statement to the task force. "The mutual goal of our associations is to work together to resolve health-care issues with the Texas Legislature, our state leaders, insurers, consumers, and other affected parties."

The task force was scheduled to release its initial draft report — including recommendations on tort reform —in August. The final report is slated to be delivered to Gov Ann Richards on November 1.

Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs section of* Texas Medicine.

Bill filed to grant antitrust protection for self-regulation

THE MEDICAL PROFESSION would have greater ability to keep its own house clean under legislation filed in Congress in June.

The measure by US Rep Bill Archer (R-Texas) would exempt organized medicine's self-policing efforts from antitrust laws that now discourage self-regulation. It is supported by both the Texas Medical Association and the American Medical Association.

US Rep Bill Archer (R-Texas)

"The medical profession is proud of its unique ethical traditions and of the pervasive peer review and standard-setting organizations it supports," said Joseph T. Painter, MD, Houston, president-elect of the AMA. "Representative Archer's bill will provide the regulatory relief needed to sustain and strengthen that tradition."

The measure provides that no damages, costs, or attorney's fees can be recovered under any federal or state law as a result of self-regulatory actions aimed at promoting quality of care. The exemption covers any medical self-regulatory entity engaged in quality-promoting, standard-setting, or enforcement activities, including physician organizations taking disciplinary action against physicians who violate the profession's code of ethics. Protection also is provided for members, officers, employees, consultants, and volunteers of such entities.

AMA lobbyist John Scott said AMA had significant input in the

ELECTION CAMPAIGNS ENTERING FINAL STRETCH

WITH THE 1992 POLITICAL scene about to move into its final swing, Texas Medical Association Political Action Committee (TEXPAC) has been focusing much of its efforts on several important state Senate and Supreme Court races.

"Labor Day to election day is the true political season," says Valerie Terry, TMA director of political education. "We anticipate there will be some very hotly contested races."

Among those are two Senate seats involving incumbents who have been longstanding friends of organized medicine. In Senate District 1, incumbent Sen Bill Ratliff (R-Mount Pleasant) is being challenged by Democrat Bob Aiken of Commerce. Another friendly incumbent, Democratic Sen Bill Haley of Center is in a tough race against Republican Gene Shull of Tyler in Senate District 3.

TEXPAC is watching closely two other Senate campaigns also expected to be hard fought. Those include the contests between Sen Ted Lyon (D-Rockwall) and Plano Republican Florence Shapiro and between Democratic Sen Bob Glasgow, Stephenville, and Jane Nelson (R-Lewisville).

In the Supreme Court races, TEXPAC has endorsed Republican challenger Craig Enoch against incumbent Justice Oscar Mauzy. TEXPAC also is supporting the reelection bids of Justices Eugene Cook, a Republican, and Jack Hightower, a Democrat.

TMA members are urged to get involved in the campaigns of TEXPAC-endorsed candidates.

Contributions to Texas Medical Association PAC (TEXPAC), Texas Medical Association PAC-Statewide (TEXPAC-Statewide), and American Medical Association PAC (AMPAC) are not deductible as charitable contributions for federal income tax purposes.

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drafting of the Archer bill, which is based on a 1984 law that provides a similar exemption for local governments acting in the public interest. The measure already has garnered some criticism that it is too broad. AMA expects opposition to the bill from the Federal Trade Commission and Department of Justice, which have opposed similar bills in the past.

At *Texas Medicine* press time, the bill was pending in the House Ways and Means Committee. Mr Scott said the panel was expected to mark up in late July or early August the health-care reform plan introduced by US Rep Pete Stark (D-California). Representative Stark's plan proposes the extension of Medicare rates to private payers and "global budgets," which would limit total health-care spending in any budget year.

A Republican health-care plan, including the Archer bill, will be offered as an alternative to the Stark bill. The Republican proposal includes small market insurance reforms, professional liability reforms, market-oriented cost containment measures, a ban on physician self-referral activities, and streamlined insurance claims processing.

Late news affects campaigns

A DECISION ANNOUNCED AT *Texas Medicine* press time has thrown the November state Senate elections up in the air. Texas Secretary of State John Hannah has ruled the elections must proceed under a redistricting plan drawn by the legislature rather than a court-imposed plan used for the March primaries. The change affects some key Senate races being monitored by TMA. Legal challenges to Hannah's decision were expected.

Senator says tobacco companies should pay for smoking-related illnesses

TOBACCO COMPANIES WOULD be hit where it hurts most — their balance sheets — if one Texas senator has his way.

State Sen Temple Dickson (D-Sweetwater) has proposed legislation to require the tobacco companies to pay part of the public costs for treating people with smoking-related illnesses. Senator Dickson, a smoker for 35 years, has been diagnosed with lung cancer.

"The effects from smoking tobacco are exacting a terrible toll on the health of Texans and on the state treasury," Senator Dickson said at a July 10 news conference. "Powerful lobbyists help the tobacco companies not only escape responsibility for the millions of dollars in health costs but to also receive subsidies from the government to grow and sell the product. This legislation will begin to loosen the grip of the tobacco industry's forces on our state and provide a means for the state and local gov-

ernments to recover the costs of treating tobacco illnesses."

The bill would establish legal grounds under the state tax code for the state, counties, or other taxing units to recover expenses from tobacco companies for treating smoking-related illnesses. Companies also would be prohibited from defending themselves in court with the argument that smokers assume all the risk of tobacco use.

The public cost of smoking-related illnesses, including lung cancer, emphysema, and heart disease, is more than $100 million annually in Texas. That includes $10 million paid by Medicaid. The American Lung Association has estimated total smoking costs in the state at more than $3 billion annually, including direct health-care costs and indirect costs, such as lost work time.

Senator Dickson will not be in the Senate next year when the legislature convenes because he lost his reelection bid in the Democratic primary. However, he said he will urge passage of the measure as a private citizen. He already has provided drafts of the bill to the governor and lieutenant governor.

"The tobacco companies know now and they have known for 50 years of the dangers of their product and it is high time for them to start paying for part of the damage they cause," he said.

The measure already has the support of Public Citizen of Texas, but has come under fire from tobacco lobbyists, who say the state already collects more than $700 million from sales and excise taxes on cigarettes. ★

All articles in Texas Medicine *that mention Texas Medical Association's stance on state legislation are defined as "legislative advertising," according to Tex Govt Code Ann §305.027. That law requires disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in* Texas Medicine*: Robert G. Mickey, Executive Vice President, TMA, 401 W 15th St, Austin, TX 78701.*

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Doctor, I read in this morning's newspaper that . . .

A headline flurry in a major newspaper reports the outbreak of ciguatera at a local seafood restaurant. Several readers, convinced they have food poisoning, contact their physician complaining of fatigue and dizziness. The only snag? None of the patients ate at the restaurant where the outbreak occurred.

"The restaurant incident involving several of my patients was a reminder of how powerful the press really is and a testimony to how much more medically aware the public is becoming," says internist John W. Burnside, MD, associate dean for professional education at The University of Texas Southwestern Medical Center at Dallas. "Our patients' thirst for medical

By Laura J. Albrecht, Associate editor

information is astonishing.

"Just look at the titles at the bookstores. There are books on self-help, nutrition, mind and body, and exercise. There are the tabloids that cure cancer every week, heart disease every 3 weeks, and sexual dysfunction every month. That's what sells the newspapers, but that is the type of reporting that worries me," he says.

Dr Burnside points out that increasingly the business of medicine is providing information. And the wealth of medical information available to the public means physicians must be ready to respond to many partially informed patients.

Obstetrician/gynecologist Tim Field, MD, Jacksonville, says, "I have patients asking me all the time about medical articles they read in magazines or TV segments they saw on the morning news show." He also has patients who ask about medical articles they just read in magazines in his waiting room

And while Dr Field, a member of the Editorial Committee for *Texas Medicine*, doesn't generally think the medical articles in the popular press are that far off base, he does screen the magazines in his waiting room. "A lot of times there are very good articles that stimulate the public's desire to be educated about a particular topic," he says. "But the articles are not always straight down the line factually and I at least want to be prepared to give patients up-to-date medical facts."

David Havemann, MD, medical director for the Options for Health program at Scott & White Memorial Hospital & Clinic, shares Dr Field's concern about helping patients to understand what they read.

Newspapers and television are excellent ways to deliver general health information, he says, but the media can raise false expectations about treatment. He also is concerned about the volume of medical information.

"Increasing awareness is good to a point," he says. "But beyond that point it can perpetuate obsession."

Pediatrician Carolyn Evans, MD, of Dallas, encourages the parents of her patients to read medical articles in the consumer press.

"No one (article) is going to be 100% accurate for each and every child," she says. "In fact, the well-written articles carry a disclaimer that suggests contacting your physician if you have any questions about the contents of the article."

George Lundberg, MD, editor of *The Journal of The American Medical Association (JAMA)*, also sees value in the medical information provided by the popular press.

"We consider journalists in the public media to be our colleagues who are providing useful medical information," he says. "A vast majority of public media reporting is accurate enough to not be misleading."

So, who are the journalists delivering that dose of medical information to your patients via the nightly news and daily newspaper?

Writing about medicine

One wanted to be a doctor. Another is a physician's daughter. And still another holds a master's degree in public health. These individuals are the top medical journalists in Texas and they take their jobs very seriously.

Dennis Johnson, a reporter with WFAA-TV in Dallas, says his lack of mathematical skills kept him from pursuing a career in medicine.

"I was always interested in the human body and through medical journalism I was able to put the two worlds together," says Mr Johnson, an award-winning reporter who has been covering medicine in Texas since 1979.

Mr Johnson says he gets the words and pictures that make up his average 1- to 4-minute broadcast from a variety of sources. Viewers may call in with questions. An article in one of the hundreds of medical journals might pique his curiosity. A doctor might have a story to share or a hospital public relations department might pitch a story idea. Or a medical research team may have synthesized a new drug.

"An important consideration in broadcast journalism is the limitation of space and time," says Mr Johnson. Another facet of developing stories for television is the need for visual impact — more than words are needed to tell the tale.

Tight deadlines, which haunt both print and broadcast journalists, can make getting the facts straight extremely difficult, but medical reporters are particularly aware of their responsibility for accuracy, since an inaccurate medical story can harm a reader.

But mistakes do happen. A correction and warning in the July issue of *Glamour* stated, "The June Health & Pregnancy (column) suggested taking 500mg boric acid tablets three times a day with meals as one method of avoiding yeast infections. This suggestion may be misread to say that boric acid should be taken orally. Do not ingest boric acid — boric acid is toxic. If you accidently ingest boric acid, call your doctor or poison-control center immediately. Before using boric acid in any form, consult your doctor."

Rita Rubin, medical writer for *The Dallas Morning News*, goes well out of her way to avoid mis-

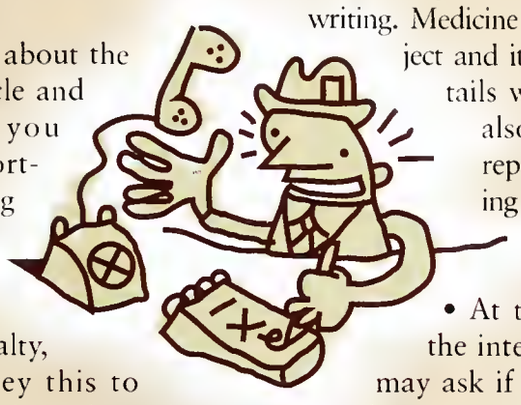
"Our patients' thirst for medical *information* is astonishing."

Hello doctor, I'm writing an article on...

Do you panic when the voice on the other end of the telephone is a reporter wanting your comments about the rate of tuberculosis in your town or the latest Medicare regulation?

Barbara Gastel, MD, who teaches a medical writing course at Texas A&M University, offers the following tips for dealing with the media.

- Ask the reporter about the focus of the article and the angle. If you don't feel comfortable commenting on the subject matter because it doesn't fall under your specialty, don't. But convey this to the reporter and explain that other physicians would be better informed to respond to the article. Offer to provide some names of colleagues you think would make good sources.
- Find out the reporter's background. Is he or she the medical reporter for the TV station or newspaper? Or a general assignments reporter? A reporter, although doing his or her best, may not be familiar with medical terminology and may need careful explanations.
- Collect your thoughts. Ask the reporter if you can return his or her call in 15 minutes, but realize that the reporter may not be able to wait if he or she is on deadline.
- Return calls promptly.
- Don't assume the reporter knows medicine. Explain the subject in the same manner you would to a patient. The less a reporter has to translate the less chance there is for error.
- Express yourself in ways you can be easily quoted.
- If feasible, provide your comments in writing. Medicine is a complex subject and it is easy to get details wrong. You might also suggest that the reporter consider using visual aids such as graphs, charts, or photographs.
- At the conclusion of the interview, a reporter may ask if there is anything else you would like to include in the article. This is a good chance to provide additional valuable information.
- Encourage reporters to call back if they have any more questions or need clarification. Offer to check the story for accuracy, but don't demand control.



"We are very pleased when doctors respond to the local media," says Lisa Stark Walsh, director of TMA's public relations department. Physicians may contact the PR department if they need assistance when responding to the media. Also, physicians who wish to voice their views on local issues may ask the PR department to help them develop letters to the editor.

takes. "If anything, I am overly cautious about what I write," she says.

A medical reporter for more than 11 years, she describes her job as "the best on the paper," but adds that writing about medicine requires understanding not just the science, but also the economic, political, and human angles. Ms Rubin, whose father is a retired physician in West Virginia, also points out that articles on medicine and health touch readers like no other stories because the contents can directly affect the quality of their lives.

Part of her cautious approach to material comes from realizing how difficult it is to predict the ways readers will react to a story. "No matter what you write people are going to believe what they want," she says.

Ruth SoRelle, the *Houston Chronicle*'s veteran medical editor, agrees. "Care has to be taken when presenting cutting-edge information to the public," she says. "Patients who are really desperate to find an answer will misinterpret everything."

"Patients who are really desperate to find an answer will misinterpret everything."

Ms SoRelle, who also has worked as a medical editor at The University of Texas M.D. Anderson Cancer Center and Baylor College of Medicine, says she is aware of the great sensitivity of many medical issues and believes she has earned a reputation as a fair reporter who presents both sides of a story.

Gaining the trust of both readers and news sources is one of the main tasks of a medical reporter. Ms Rubin mentions how valuable physicians' trust can be.

"I need the physician's help because I am trying to get the story right," she says. But she also knows that physicians' schedules can make it difficult for them to respond. "I don't expect a doctor to run out of surgery to answer my call," she says.

With health and medical articles consuming more space in newspapers and more time on radio and TV, more opportunities exist for journalists who want to write about "what ails and what cures."

Among those training future medical journalists is Barbara Gastel, MD, who will teach a medical reporting course this fall at Texas A&M University. She hopes the course will attract not only journalism students, but future doctors as well.

"Communication involves at least two people," says Dr Gastel, associate professor of journalism and humanities in medicine at Texas A&M University. "This course will give reporters a better understanding of medicine and, in turn, physicians will understand more about the media."

Pregnant man gives birth!

Man explodes while passing gas. Taking the Pill cuts your risk of getting arthritis. Woman doc is antidote to high blood pressure.

These tabloid headlines are among those your patients could have read while waiting in line at the grocery store recently. They appeared in the *Weekly World News*, *National Enquirer*, and *Star*.

While grocery store tabloids are known for their sensationalism, there is no denying they are popular. Three million copies of the *Star* are sold each week. According to Magazine Publishers of America, these three publications rank in the top 20 of single copy sales.

But really now, just how accurate are the headlines and articles?

Once past the provocative headlines, the information in the articles is far less outrageous than many people expect.

"We go further than any other publication when confirming sources for articles," says Ed Susman, medical reporter for the *National Enquirer*. "Our medical coverage has to not only be interesting, but useful to the reader."

The *Star*'s medical editor, Christina Kirk, says her publication reaches a lot of individuals who would normally not be exposed to medical information. "Our accuracy record is pretty good and we haven't received any major complaints from the doctors," she says.

Ms Kirk says she doesn't write the headlines, but she will call it to the headline writer's attention if she believes one is misleading.

"You can't be flip or high-handed when doing medical coverage," says Mr Susman. "You print the wrong thing and it might change how a person seeks medical care."

Now, in case you missed the articles mentioned above: The pregnant man who gave birth was a hermaphrodite. The man who exploded passed gas while walking near an acetylene torch that ignited methane in his intestines. The Pill story was developed from a University of Washington study. And the "woman doc" story reported on a University of Kentucky College of Medicine study that women had higher blood pressure readings when a man took their blood pressure.

The course will address basic techniques in medical writing, newsworthiness in medicine, medical ethics and health policy, environmental and occupational health, and sources of news.

Medicine on the tube

Taking a step beyond serving as primary news sources for medical articles, some physicians now also work as medical reporters. Indeed, it is no longer an oddity to see a physician on a major network or the local nightly news. And television news programs such as *20/20*, *60 Minutes*, and *48 Hours* also frequently focus on medical topics.

Susan Schiller, senior producer of the medical unit of *CBS This Morning*, says her program makes a concerted effort to focus on health issues by scheduling a minimum of seven health segments per week. Health stories for the program fall into three basic categories — consumer information, "breaking news," and human interest. Examples of consumer information stories include those on breast cancer, vitamins, menopause, and other subjects with broad appeal. The breaking news category might include stories about celebrities who announce they have AIDS or a controversy over a new pharmaceutical drug. Human interest segments focus on individuals, either patients or physicians.

"Our job at *CBS This Morning* is to give viewers information that will help them become better consumers of health services," says Ms Schiller. "We try at least to give the message that viewers have the right to ask their physician, health-care provider, or insurer questions about their care."

Guiding the media

Every week, the public relations department at the American Medical Association sends out more than 3,000 press packets describing the contents of the most recent edition of *The Journal of the American Medical Association* to reporters, editors, freelance writers, and other news outlets in 22 countries.

Reporters also watch *The New England Journal of Medicine* and numerous other medical journals for possible stories. They talk to physicians, researchers, patients, and hospital personnel in search of the story that will catch the attention of viewers and readers.

Like the AMA, the Texas Medical Association maintains a strong relationship with the news media to ensure that the medical point of view is

"Controversy and conflict are the nuggets reporters look for."

What have your patients read lately?

Hundreds of magazine titles hit the newsstands, your patients' mailboxes, and your waiting room tables every week. And the trend is toward more medical topics in those publications. Even the American Medical Association has joined forces with *Good Housekeeping* to create *Living Well*, a newsstand magazine geared toward consumer health topics.

Here's a sample of the medical cover stories that some recent magazines gave top billing:

- "TB: Why it's back and how we can protect ourselves" — *Newsweek*, March 1992.
- "The doctor who wouldn't let me die" — *Good Housekeeping*, May 1992.
- "Pay less for prescription drugs" — *Redbook*, May 1992.
- "America's best hospitals: How to find top care in 16 specialties" and "Picking the right emergencies" — *U.S. News and World Report*, June 1992.
- "Contact tracing to control AIDS" — *The Saturday Evening Post*, June 1992.
- "The nightmare of childhood sexual abuse" — *Cosmopolitan*, May 1992.
- "Why doctors miss breast cancer" — *New Woman*, May 1992.

Other non-cover-story medical topics recently included:

- *American Health* (July/August 1992): Articles on cosmetic surgery, Olympic fitness, contact lenses, cancer survivors, dental care, chiropractors, and national health care.
- *Family Circle* (June 1992): Infections your doctor may have missed. Can broccoli really prevent cancer? News on contact lenses, cumulative trauma disorder, hot flashes, and skin cancer.
- *Health* (July/August 1992): Interviews with women whose birth control methods failed. Also, a rating of new substitute foods. And, true confessions of a pathological liar.
- *Reader's Digest* (June 1992): Cancer weapons. Questioning health insurance. How to have a thinner waist in 30 days. How to make sure your kids never start smoking.

Patients also have access to professional medical literature through public libraries. For example, the Austin Public Library carries *RN Magazine*, *The Journal of the American Medical Association*, *Patient Care*, *The New England Journal of Medicine*, and *Nursing '92*.

heard and that medical stories are accurate. The TMA public relations department responds daily to media inquiries, sends news releases each month on *Texas Medicine*, and also sends a bimonthly health column, *HealthTips*, to both print and broadcast media.

"Controversy and conflict are the nuggets reporters look for," says Lisa Stark Walsh, director of TMA's public relations department. "Our challenge is to persuade the media with good evidence and data that they should present our point of view."

According to Ms Stark Walsh, two types of reporters write medical stories. One focuses on topics such as medical research. The other, a newer breed of medical reporter, applies his or her expertise in investigative reporting to medical stories such as the recent psychiatric hospital scandal. These reporters also write about funding of government health programs and other complex health-related topics. Most major and mid-size media markets in Texas have designated health and medical reporters.

"Doctors are the best barometers of medical coverage," says Ms Stark Walsh. She adds that they can help elevate the level of reporting by notifying editors of inaccuracies in local newspapers and on radio and TV broadcasts and also by telling them about a job well done.

"Newspaper medical reporters are doing a better job at being fair and comprehensive," says Jeff Molter, director of the AMA department of science news. He adds that the broadcast media has a tough challenge because of time restraints. If information is presented in a confusing manner, "then the doctor has to spend 30 minutes calming the patient down and another 30 minutes explaining what he or she heard or watched," he says.

He recommends that physicians stay alert to medical material in the popular press because patients are using the information to make health-care decisions. "The patient is a lot smarter and more knowledgeable and is pushing the physician to be a better communicator," he says.

Dr Burnside, chairman of the TMA Council on Scientific Affairs, has had direct experience with patients asking about medical articles. "The fact that radio, television, and newspapers have highlights of the hottest items from *The New England Journal of Medicine* the day before the issue goes to physicians makes me open my mail first thing the next day because I know a patient may call to ask me about a journal-related article," he says.

Newsletters and brochures add to the mix

Beyond the steady stream of medical information coming from the popular press is a growing assortment of health newsletters and patient education materials. The edi-

Quenching patient education thirst at TMA Library

One of your patients is HIV-positive. Another is in search of a new diet. Still another is battling alcoholism. You want accurate information to give your patients so they can better understand their illnesses. Where do you begin your search?

The Patient Information Collection at the Texas Medical Association Library consists of books, pamphlets, audiovisuals, and other materials designed for the patient. Approximately 1,000 pamphlets and photocopied articles, 200 books, and more than 50 audiovisual programs are included in the collection. The library also has access to the Combined Health Information Database, which is designed to search for medical information found in the consumer press.

Physicians may request information from the PIC by calling (800) 880-1300, ext 1550 or (512) 370-1550.

tors and writers of these products say their task is to educate, but certainly not to take the place of the family practitioner.

"What we try to do with our newsletter is help people understand what they can do to improve and maintain their health," says Joe Sigler, editor of The University of Texas Health Science Center at Houston *Lifetime Health Letter*. What started as a health promotion vehicle in the early 1980s has become a newsletter with almost 100,000 subscribers in 50 states.

Mr Sigler says a recent survey of 500 subscribers revealed "a real hunger for medical information." Of those surveyed, 21% subscribe to one health newsletter, 13% subscribe to two publications, and 28% subscribe to three or more.

"Medicine is a hot topic," says Don Nelson, director of the department of public affairs at Scott & White Memorial Hospital & Clinic. "Our main thrust is high-tech, high-touch. We present topics that are currently being talked about." Mr Nelson's department produces *Options for Health*, an 8-page tabloid that is inserted into 19 newspapers across Central Texas. Scott & White also provides health information to radio and television stations and encourages its physicians to be responsive to media inquiries.

A firm believer in patient education materials is W.R. Spence, MD, whose Waco company, WRS Group, Inc, specializes in medical education products. "Health education is part of any delivery of health care," he says. "If you don't believe in education, then you are in big, bad trouble."

Margaret Leary, who works with Dr Spence, oversees the editorial and art production of patient information pamphlets. The pamphlets, which are marketed internationally, cover a wide variety of subjects ranging from antidrug, antidrinking, and antismoking messages, to explanations of the 20 most common diagnostic tests and 13 most common day-surgery procedures. Each brochure carries a disclaimer that the information is not a substitute for medical care and that diagnosis and treatment should be done only by a physician.

Ms Leary says information for the brochures comes from a host of sources: physicians, journals, medical books, libraries, and health organizations. Facts must be confirmed by two written sources.

"We are very particular," says Ms Leary. "Sources for pamphlets are kept on file so we can locate them immediately if there are any questions." Products are updated on a 2-year cycle. Current pamphlets cover topics such as laparoscopy, cataract removal, abdominal sonogram, hysteroscopy, and computerized tomography.

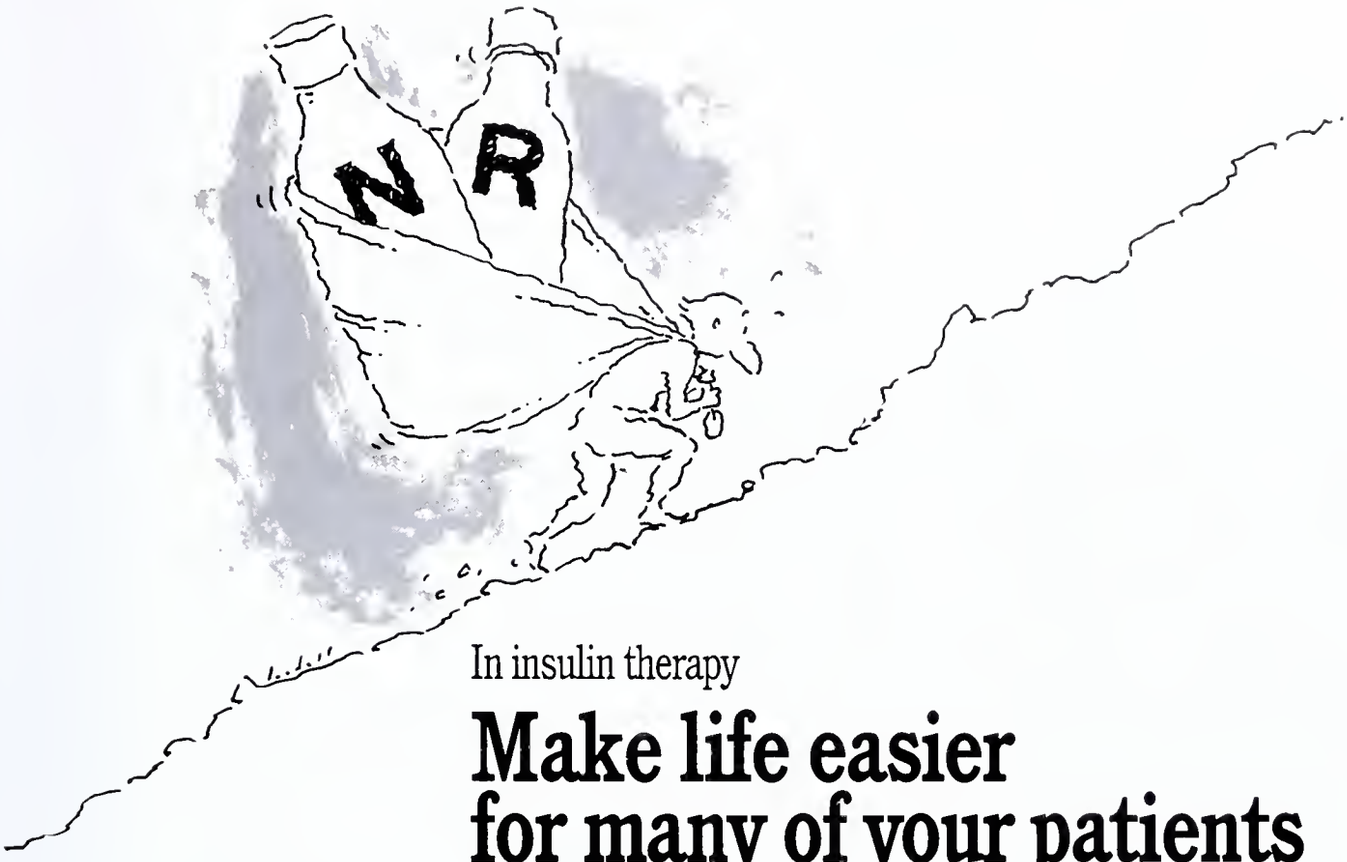
Telling the truth

Given the daily avalanche of medical information from magazines, television, radio, and newspapers, are patients able to distinguish the accurate information from the erroneous?

In an informal survey of TMA staff, the great majority selected "maybe" when asked if they believed the medical information published in newspapers and magazines or broadcast on television and radio. While some respondents did find the news media's presentations of medical information credible and said they had gained valuable information from what they had read and seen, others regularly doubted the articles and wondered about the sources used by reporters.

Perhaps the best advice about trusting health news is: "Be careful of what medical information you read; you could die of a misprint." ★

"Health education is part of any delivery of health care."



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Public Health

Poison control centers combine education and expertise to save lives

Poison control centers in Texas are open and accessible not only to physicians, but also to the public. In a series of articles, Texas Medicine *will examine the availability of poison information from the North Texas Poison Center and The University of Texas Medical Branch at Galveston, hospital-based centers, funding, legislation, personnel, and the future of the centers.*

AN EXPLOSION ROCKS A chemical manufacturing plant. A frantic mother discovers her child has eaten a leaf off a household plant. And playful dolphins at a marine park become ill after glue used to secure carpet begins to flow into their tank.

All of these incidences have one common denominator. Contacting a poison center provides prompt access to the pressing questions of what is the toxic substance causing the problem and what is the treatment.

"If you can ingest it, inject it, inhale it, bite it, or be bitten by it, or smear it on your skin, then it fits into our area," says Michael D. Ellis, RPh, director of the Texas State Poison Center (TSPC) at The University of Texas Medical Branch at Galveston.

Although there are poison centers located in hospital emergency rooms across the state, the North Texas Poison Center (NTPC), based at Parkland Memorial Hospital, and TSPC are certified by the American Association of Poison Centers with staff (registered nurses or pharmacists trained in poison information) whose sole responsibility is to respond to hotline calls concerning exposure to potentially toxic substances.

"What sets us apart from other poison centers in the state is that our staff is 100% dedicated to the task of taking hotline calls," says Lena C. Day, RN, CSPI, manager of NTPC. Poison centers based in hospital emergency departments or pharmacies have staff with the shared responsibilities of responding to their own cases in addition to answering calls concerning poison exposure, says Ms Day.

Ms Day says some physicians were apprehensive at first about the center's ability to provide information. "As we gained expertise and began working with the doctors they realized we provided a valuable service."

> "IF YOU CAN INGEST IT, INJECT IT, INHALE IT, BITE IT, OR BE BITTEN BY IT, OR SMEAR IT ON YOUR SKIN, THEN IT FITS INTO OUR AREA."

The birth of poison centers

The concept of poison centers became popular in the 1950s when a pilot project was begun in Chicago. Following its glowing success, facilities were opened to provide toxicologic guidance. However, problems of funding and staff training inched into the system.

Mr Ellis, who arrived at UTMB in 1972, says poison control centers in Texas were slow to train staff to respond to toxicology emergencies. "There were lots of places with shingles out and it was becoming a dangerous situation."

What started as a good idea became a system engulfed with questions of who's going to pay the bills and handle the liability that emergency room staffs were confronted with when dispensing information over the phone. This resulted in programs being canceled, which placed an added burden on the remaining facilities.

In search of cost effectiveness

Today, problems of funding and staffing still exist. Parkland Memorial Hospital recently sent more than 450 letters to county commissioners, city managers, and hospital administrators requesting funds to keep NTPC in operation. The Dallas County Hospital District has been paying the majority of the center's costs.

The problem of securing funding can be linked to a lack of knowledge among those who control the purse strings. "When we started the funding campaign we talked to groups to explain the need for the money and discovered that the people we were talking to had no earthly idea what a poison control center did or how it functioned. We explained that we were not only cost-effective, but we also saved lives," says Ms Day.

One important cost-effective aspect of poison control centers is the ability to resolve problems through home treatment procedures. In 1991, the NTPC staff received 68,611 calls and out of those calls, 80% were resolved through home treatment procedures. Ms Day says this avoids the need for dispatching ambulances or unnecessary hospital emergency room visits.

"Texans are living in a world with about 800,000 products that have the potential to be harmful.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

Cancer claims lives of 28,483 Texans during 1990

THE SECOND LEADING CAUSE of death behind heart disease in 1990 was cancer, which killed 15,622 men and 12,861 women in Texas, according to the Texas Department of Health. Lung cancer was the leading cause of cancer death among both men and women.

Other items reported by the TDH Cancer Registry Division were:

- Prostate cancer claimed the lives of 1,693 males.
- Breast cancer was the second leading cause of cancer death among females.
- Cancers of the colon and pancreas were the third and fourth most common cancer sites for both men and women.
- White females had higher rates of lung cancer than Hispanics and blacks.
- Black females experienced higher rates of breast cancer than whites and Hispanics.

Many of the cases we respond to are very simple and take 2 minutes to deal with," she says. "Others are more complicated and require a lot of time and expertise."

Cancer pain treatment to be addressed during statewide meeting

MISCONCEPTIONS AND myths about the role narcotics play in the treatment of pain in cancer patients will be addressed in Austin at a statewide meeting of the Texas Cancer Pain Initiative in October.

"There is a great knowledge deficit among physicians and other health-care professionals on the subject of treating pain," says C. Stratton Hill, Jr, MD, president of the Texas Cancer Pain Initiative (TCPI). "They don't know how to treat pain."

The controversy surrounding the use of narcotics in treating cancer patients centers around the three following areas: cultural and attitudinal barriers; knowledge deficit among doctors and health-care professionals; and state and federal drug regulatory agencies.

The initiative was created in June 1991 with a mission to promote optimum pain relief for all cancer patients, regardless of the stage of their disease or prognosis. Working closely with the TCPI to distribute educational materials is Texas Medical Association's Physician Oncology Education Program.

The keynote address for the October 30–31 meeting at the Marriott Hotel will be given by Reginald Ho, MD, president-elect of the American Cancer Society. Dr Ho has chosen pain relief for cancer patients as the focus of his term. In addition to a full slate of guest speakers, an open dialogue will be encouraged on legal issues pertaining to prescribing narcotics to relieve cancer pain. Taking part in the discussion will be representatives from the Texas State Board of Medical Examiners, Texas State Board of Nurse Examiners, Texas State Board of Pharmacy, Texas Department of Public Safety Narcotics Division, and US Drug Enforcement Administration.

Speakers will discuss the following topics:

- *Developing a Physician Education Program for State Initiatives — What Works?* David Weisman, MD, Medical College of Wisconsin.
- *Selection of Opioids for Treating Cancer Pain — Pharmacological Principles.* Charles Inturessi, PhD, Cornell Medical College.
- *Quality Pain Management — Myth or Reality.* Christine Maiskowski, PhD, University of California, San Francisco.
- *A Covenant with Patients: The Moral Management of Pain.* Roy Martin, MD, Cook-Fort Worth Children's Medical Center.
- *The Relationship Between Psychosocial Factors and Undertreatment of Cancer Pain.* Matthew Losalzo, ACSW, Memorial Sloan-Kettering Cancer Center, New York.
- *Treatment of Pain in Patients with Cancer Who are Currently Substance Abusers or Who Have a History of Substance Abuse.* Richard Payne, MD, The University of Texas M.D. Anderson Cancer Center.
- *Intractable Pain Treatment Act of Texas.* C. Stratton Hill Jr, MD, The University of Texas M.D. Anderson Cancer Center.
- *The Need for a Positive Regulatory Policy on Cancer Pain Management.* David Joranson, MSSW, Pain Research Group, University of Wisconsin Medical School.

Preregistration is $85 if received by October 1; late registration is $100. Information is available from the Texas Cancer Pain Initiative, PO Box 980185, Greenbriar Station, Houston, TX 77098-0185.

AGENDA ON AIDS

HIV and AIDS awareness at TMA

Understanding the psychological effects of AIDS, treating children and women with AIDS, and the importance of medical histories will be some of the topics discussed during an October 30 comprehensive clinical training session sponsored by the Texas Medical Association in Austin. Under the direction of the TMA public health and scientific affairs department and the AIDS Regional Education and Training Centers for Texas and Oklahoma, the session also will cover current OSHA infection control regulations and clinical trials. Registration information is available from TMA at (800) 880-1300, ext 1461, or (512) 370-1461.

Survey studies HIV infection rate in infants

An ongoing Texas Department of Health survey reveals that an estimated 30% of babies born to HIV-positive mothers also will be infected by the virus. The sampling tested 97,000 blood samples from newborn babies. Out of this group, 87 tested positive for HIV. The study also revealed that of the 50 known ages of the mothers, 15 were 19 years old or younger.

TDH film library offers HIV/AIDS videos

Videos for physicians, AIDS patients, and their families are available from the Texas Department of Health Media Library. Titles include "AIDS, HIV, and Seroconversion: What You Should Know"; "AIDS: Issues for Health Care Workers"; "AIDS Prevention for Laboratory Professionals"; "Condom Negotiation Skills for Health Care Professionals"; "Counseling for the HIV Antibody Test"; "HIV Blood Test Counseling Guidelines"; "Invitation to a Virus"; "The New Tradition: Safer Sex Counseling"; "Universal Precautions: Guidelines for Long Term Care Facilities"; "Are You Positive: HIV Testing for Women"; and "Condom Talk." Videos are free upon request from the TDH film library at (512) 548-7260.

AMA, CDC survey physicians on HIV treatment and prevention

More than 12,000 primary care physicians were asked to take part in an American Medical Association and Centers for Disease Control survey of physicians' HIV treatment and prevention practices. The survey, which was mailed at the end of July, will measure and collate a range of information about physician practices and HIV management, including practice types, information provided to patients about HIV, community awareness, national resources for HIV-infected individuals, attitudes about those infected, and the possibility of on-the-job exposure to HIV. Survey results will be used to develop AIDS education programs for physicians and other health-care personnel. "Physicians learn as much about HIV management on the job as they do from any other source," says James S. Todd, MD, AMA executive vice president. "This survey will ensure that subsequent AIDS education programs are based on the real experiences and knowledge of primary care physicians who deal with the epidemic every day."

Is AIDS a reportable disease in Texas?

Yes. AIDS is a reportable disease in Texas. AIDS cases should be reported by phone or in writing to the local health authority. If your area does not have a city or county health department, case reports and information should be sent directly to Texas Department of Health, Surveillance-406, 1100 W 49th St, Austin, TX 78756. Prompt reporting of AIDS cases is extremely important. In the case of transfusion-associated AIDS, HIV-infected donors must be located. Reporting is also necessary so that federal funds for prevention, education, and support can be allocated accordingly. Under the Communicable Disease Prevention and Control Act, all reports are confidential and may be used only for the purpose of the act or for statistical and epidemiological studies.

Richard M. Grimes, PhD, director of the AIDS Regional Educational and Training Centers for Texas and Oklahoma at The University of Texas at Houston School of Public Health, will provide answers about AIDS each month in this column. For further information about this topic or any HIV topic, call the AIDS Helpline for Health Professionals at (800) 548-4659.

COMMENTARY

A need for balance: preventive and therapeutic medicine

David R. Smith, MD
Texas Commissioner of Health

AESCULAPIUS, THE GREEK god of medicine, had two quarrelsome daughters: Hygeia, the goddess of health, known for preventing illness; and Panacea, the goddess of cures, known for treating illness. They began life as equals, but eventually Panacea was given preference. Society came to value the immediacy of relieving the suffering of the sick more than the less obvious, long-term benefits of maintaining health.

The status of the two sisters became more and more disparate. Without Hygeia's full beneficence, more people became sick. The demand for Panacea's services exceeded her capacity to heal. The price for her help soon outstripped many patients' ability to pay.

These goddesses embody the age-old competition between medical or curative care and disease prevention, still much in evidence today. This sibling-like rivalry has left us with a disjointed, fragmented health-care system — a system unresponsive to the needs of our communities. Our current system is out of balance. It fails to take advantage of the human and economic savings that can be realized by avoiding illness. And, it fails to offer sufficient treatment capacity to meet the needs of the sick. In short, it fails to provide adequately for the public's health.

Examples of Panacea's failures abound. In Texas, lack of capacity to provide medical or curative care is illustrated by our vast Health Professional Shortage Areas and Medically Underserved Areas.

Likewise, Hygeia's failures are apparent. The sad consequences of inadequate health maintenance and preventive health care include the resurgence of measles and tuberculosis and the rising percentage of infants with low birth-weights.

> "WE CAN NO LONGER AFFORD A HEALTH-CARE SYSTEM BASED ON SICKNESS RATHER THAN ON HEALTH."

We can no longer afford a health-care system based on sickness rather than on health — one in which the imbalance between primary care and prevention leaves both modes incapable of fulfilling Americans' health and medical needs.

The popular health-care reform debate becomes meaningless, unless our system has the capacity to care for those who currently lack access to the system. Even if we issued every medically indigent American a magic plastic card labeled "National Health Care Insurance," the needs of many would go unmet.

Solving the health-care problem in America must begin by building capacity — for both primary care and prevention. And in doing so, we must take advantage of the opportunity to correct the ancient inequity between treating diseases and preventing their occurrence and to create a new vision that links primary care and public health. It could be the beginning of a long-term reconciliation between Panacea and Hygeia.

Attempts at such a reconciliation are not without precedent. The concept of integrated care has been labeled community-responsive medicine and Community Oriented Primary Care (COPC).

COPC minimizes fragmentation by reducing barriers such as transportation and by co-locating services, such as laboratory; pharmacy; radiology; health education; Women, Infants, and Children (WIC) services; and immunizations, in one site. It is a way of practicing medicine that blends traditional primary care with preventive public health.

While primary care focuses on the individual patient or "user" and does not assume responsibility for the health status of the community at large, COPC is driven by the defined need for health services identified within the target community. By combining obstetrical, gynecological, pediatric, and adult medicine with preventive public health services such as immunization and communicable disease control, COPC proactively aims to reduce the incidence of diseases that can lead to costly hospital care.

The successful application of COPC in this country is documented in seven case studies reviewed in a 1983 report by the National Institute of Medicine and in a large COPC program operated by Parkland Memorial Hospital in Dallas.

The Parkland program, affiliated with The University of Texas South-

western Medical School, focuses health services to six at-risk communities in Dallas County that were identified in a county-wide needs assessment. It includes five health centers that handle in excess of 110,000 patient visits annually and has resulted in significant improvements in the health of the community, including reductions in emergency room admissions, the incidence of teenage pregnancy among Hispanics and African-Americans, and death rates for adolescents.

Such community-responsive care is an attempt to move beyond the current maze of disjointed programs that fail to capture and maintain individuals in a comprehensive care system. COPC's broader success, however, will demand the preparation of physicians and other health professionals who can recognize the evolving needs of society and respond with effective preventive and therapeutic measures. It also will require government support.

Federal support — one barometer of national health priorities — for service delivery has grown only sparingly over the last 10 years, while dollars for research have expanded substantially. Similarly, aside from the growth in Medicaid expenditures, the majority of which still go toward catastrophic and long-term care, US Department of Health and Human Services expenditures for primary care service delivery show negligible growth in the past decade after correction for inflation.

Government should not only invest in the infrastructure necessary to build adequate primary care capacity, but also in the expansion of Medicaid to cover cost-effective preventive services such as childhood immunizations, prenatal and maternity care, mammography and colon screening, as well as traditionally nonreimbursable services such as nutrition counseling, outreach, case management, and overall health education.

This nation has a vested interest in the health of its citizens as we speed toward the 21st century with an aging population, a potential shortfall in our labor force, and the next public health crisis that will test our system of care. We must protect our investment by building health-care capacity wherever it is needed. For the health of our citizens, for the future of our labor force, and for the economic imperative to curb the uncontrolled growth of health-care costs, we also must change the fractured way health care is delivered in America.

We must seize this opportunity to end the wasteful discord between Aesculapius' daughters, to reunite Hygeia and Panacea by building capacity in both preventive and therapeutic medicine and by promoting the concept of Community Oriented Primary Care. ★

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OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

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Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions**: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS**: **Special Risk Patients**: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. **Cough Reflex**: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. **Drug Interactions**: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Usage in Pregnancy**: **Teratogenic Effects**: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic effects**: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. **Labor and Delivery**: Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Nursing Mothers**: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use**: Safety and effectiveness in children have not been established. **ADVERSE REACTIONS**: The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System**: Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes. **Gastrointestinal System**: The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System**: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression**: Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE**: VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. **OVERDOSAGE**: **Acetaminophen Signs and Symptoms**: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms**: Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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Law

CDC directs states to set policy on HIV-infected health-care workers

DESPITE MONTHS OF controversy and anticipation, the Centers for Disease Control (CDC) has backed down from issuing a list of exposure-prone procedures. Instead, the CDC handed states responsibility for developing policy on HIV-infected health-care workers.

In a June 18, 1992, letter to state health officials, the CDC reported that exposure-prone invasive procedures were best determined by local review panels on a case-by-case basis taking into consideration the procedure, skill, technique, and, if applicable, impairment of the infected health-care worker.

"Our state law (House Bill 7) is equivalent to the CDC July 1991 guidelines," says Charles E. Bell, MD, chief of the Texas Department of Health Bureau of HIV and STD Control. Dr Bell said nothing has really changed regarding policy on HIV-infected health-care workers as a result of the CDC decision.

Texas physicians are required to follow the provisions of HB 7, which includes adherence to CDC's "universal precautions," knowledge of personal HIV status, and seeking counsel from local review panels. (See "HIV-infected health-care workers: Texas law," *Texas Medicine*, March 1992, pp 48–49 and "Laws address issues relating to HIV-positive doctors, health-care workers," p 52, this issue.)

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

COURT RULING FAVORS RETIREMENT PLANS

A RECENT US SUPREME Court decision on pension plans and bankruptcy should reassure physicians who had wondered if their retirement plans would be safe if they were propelled into bankruptcy by a successful professional liability judgment, says Helene Alt Thompson, JD, TMA associate counsel.

Her article in the May 1992 issue of *Texas Medicine*, "Decision guards pensions from bankruptcy," pp 53–55, covered an earlier 5th Circuit Court decision that Employee Retirement Income Security Act (ERISA) qualified pension plans were protected from creditors.

The US Supreme Court decision in *Patterson v Shumate*, (60 USLW 4550 [June 16, 1992]) states that ERISA-qualified pension plans are not part of individuals' bankruptcy estates and thus are protected from bankrupt individuals' creditors. The court found that ERISA-qualified pension plans were trusts with transfer restrictions enforceable under "applicable nonbankruptcy law," therefore falling within an exception to the rule that all legal and equitable interests of a debtor in property become part of the bankruptcy estate.

The Patterson decision also noted that other types of pension plans, like individual retirement accounts (IRAs), can be excluded from the bankruptcy estate by a debtor if the debtor elects a federal scheme to exempt property. Due to the enactment of Tex Prop Code Ann §41.0021 (Vernon Supp 1992), IRAs and the like will also be protected from creditors when debtors select a state exemption scheme.

Two seminars to tackle problems of medical families and impaired physicians

DEVELOPING BETTER communication within medical families and understanding physician impairment are the focuses of two conferences sponsored or cosponsored by Texas Medical Association's Committee on Physician Health and Rehabilitation. TMA designates both conferences as meeting the criteria for credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

- *Help! My Dad/Mom is a Doctor: Communication in the Medical Family.*
Designed to teach effective techniques for improving medical family relationships, the conference is scheduled Saturday, October 3, 8 am to 3:15 pm, at the La Mansion Del Rio Hotel in San Antonio. The program will feature such topics as Professional Family vs Biological Family; The Impact on Early Childhood in Two Career Couples; Coping with Adolescent Years; "Good" Families Having Trouble: How it Happens and What Can Be Done; Fifty Ways to Keep Your Lover; and a panel discussion on communication techniques to establish and build healthy medical marriages. To register, send $40 for physicians and $30 for family members to Linda Kuhn, Texas

Legal articles in Texas Medicine *are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.*

Medical Association, 401 W 15th St, Austin, TX 78701, (800) 880-1300 or (512) 370-1342. Preregistration deadline is September 23.

- *Annual Texas Health Professionals' Peer Assistance Conference.* Presented by the Liaison Committee of Health Care Professionals' Peer Assistance Programs, the conference will provide information about developing or improving peer programs for impaired professionals. The conference, Sunday, November 1, 1992, 8 am to 5 pm, at the Texas Pharmaceutical Association, Austin, will teach participants how to intervene with impaired professionals. Among topics to be presented are: A Recovering Physician's Story; Intervention Role Playing; Types of Intervention; and Nuts and Bolts of Peer Assistance Programs for Professionals. Preregistration is $40 if received by October 16 and $50 after that date. To register, contact Texas Pharmacy Foundation, Peer Assistance Conference, Texas Pharmaceutical Association, PO Box 14709, Austin, TX 78761. For further information contact Ms Kuhn at TMA, (800) 880-1300 or (512) 370-1342.

Physicians can avoid penalties by posting required safety signs

Helene Alt Thompson, JD
TMA Associate Counsel

SEVERAL FEDERAL AND STATE laws require that notices be posted to advise employees of their rights under the law. Posting requirements are based on the number of individuals employed.

Most physicians, because they employ fewer than 15 employees, will only be required to post certain notices.

All physicians' offices

Federal postings

- Occupational Safety and Health Act (1) — This act requires an employer to furnish each of his employees a place of employment that is free from recognized hazards that cause or are likely to cause death or serious harm to employees. Job Safety and Health Protection Poster (OSHA Poster 2203) may be obtained from any local office of the Occupational Safety and Health Administration of the Department of Labor.
- Employee Polygraph Protection Act (2) — This act generally prohibits employers from using polygraph tests. Employee Polygraph Protection Act Poster (WH Publication 1462) may be obtained from any local office of the Wage and Hour Division of the Department of Labor.
- Fair Labor Standards Act (3) — This act sets standards for minimum wage, overtime pay, and child labor. Federal Minimum Wage Poster (WH Publication 1088) may be obtained from any local office of the Wage and Hour Division of the Department of Labor.

State postings

- Texas Workers' Compensation Act (4) — This act generally provides for compensation benefits to employees who have sustained work-related injuries. Three notices must be posted both in English and Spanish: notice of insurance or no insurance, OMBUDSMAN Notice, and Safety Notice. These notices were contained in the New Law Guide published by the Texas Workers' Compensation Commission. If you did not receive the guide, write the Texas Workers' Compensation Commission, Public Information Office, 4000 S Interstate 35, Austin, TX 78704-7491.
- Texas Payday Law (5) — This law provides for the payment of wages on designated paydays — at least once a month for employees who are exempt from the overtime provisions of the Fair Labor Standards Act and for all other employees at least as often as semimonthly. The payday notice may be obtained from any local office of the Texas Employment Commission.
- Texas Unemployment Compensation Law (6) — This law provides for the payment of unemployment compensation benefits for individuals who have been discharged from work. The Unemployment Compensation Information notice may be obtained from any local office of the Texas Employment Commission.

Physicians' offices with more than 15 employees

Federal postings

- Title VII of the Civil Rights Act of 1964 (7) — This act prohibits employment discrimination based on race, color, religion, sex, or national origin.
- Age Discrimination in Employment Act (8) — This act prohibits discrimination based on age for individuals who are 40 or over (applies to employers with 20 or more employees).
- Americans With Disabilities Act (9) — This act prohibits, among many other things, job discrimination based on disability (applies to employers with 25 or more employees and on July 26, 1994, to employers with 15 or more employees).

Consolidated EEOC Poster (EEOC-P/E-1-2-92), which covers the above

three acts, may be obtained from any local office of the Equal Employment Opportunity Commission. Please note that the consolidated poster contains postings of other employment laws like the Rehabilitation Act (10) and the Vietnam Veterans Readjustment Act (11) which typically do not apply to physicians' offices.

In keeping within the mandate of the above laws, notices should be posted in conspicuous places. It is suggested that physicians' offices post the required notices on a bulletin board designated for employee notices. Some physicians may wish to buy posters from private enterprises who copy the free government posters and consolidate them in one or two posters in order to avoid clutter. Not posting required notices may result in financial penalties of varying costs (12).

References

1. 29 USCA §657(c)(1) (West 1985) and 29 CFR §1903.2.
2. 29 USCA §2003 (West Supp 1992) and 29 CFR §801.6.
3. 29 CFR §516.4.
4. Tex Rev Civ Stat Ann 8308-3.24, art 8308-5.41 and 8308-7.08 (Vernon Supp 1992) and 28 TAC §110.102 and §160.1.
5. Tex Rev Civ Stat Ann art 5155 §4 (Vernon Supp 1992).
6. Tex Rev Civ Stat Ann art 5221b-4(a) (Vernon 1987).
7. 42 USCA §20000e-10 (West 1981) and 29 CFR §1601.30.
8. 29 USCA §627 (West 1985) and 29 CFR 1627.10.
9. 42 USCA §12115 (West Pamp 1992) and 29 CFR §1601.30.
10. 41 CFR §60-741.6(g)(9).
11. 41 CFR §60.250.6(g)(9).
12. 29 USCA §666 (West 1985), 29 USCA §2005 (West Supp 1992), 28 TAC §110.102, Tex Rev Civ Stat Ann art 8308-5.41 (Vernon Pamp 1992), Tex Rev Civ Stat art 5221b-17 (Vernon 1987), and 42 USCA §2000e-10 (West 1981).

Laws address issues relating to HIV-positive doctors, health-care workers

Hugh M. Barton, JD
TMA Assistant General Counsel

How can a medical practice appropriately protect itself and its patients if it has a physician or other health-care worker who has been diagnosed as HIV positive? The answer is complex because it is based on three areas of law: Texas law, the Americans with Disabilities Act, and developing case law.

Q: Does Texas allow a medical employer to require health-care workers to undergo HIV tests?

A: Texas law allows an employer to require employees to undergo HIV testing if the test is necessary "as a bona fide occupational qualification and there is not a less discriminatory means of satisfying the occupational qualification" (1). A bona fide occupational qualification means, in this sense, something related to the performance of job duties, and that there is reasonable cause to believe that the person with the condition would be unable to safely perform his or her job duties. Since certain legal limitations are placed on HIV-infected health-care workers, it stands to reason that knowing the worker's HIV status may be an "occupational qualification."

Q: What limitations does Texas law place on HIV-infected physicians?

A: As enacted by the legislature in 1991, current Texas law provides:

- All health-care workers shall adhere to universal precautions.
- Health-care workers with exudative lesions or weeping dermatitis shall refrain from all direct patient care and from handling patient care equipment and devices used in performing invasive procedures until the condition resolves.
- Health-care workers who are HIV-infected or HBV-infected (and are HBeAg positive) may not perform an "exposure-prone" invasive procedure without informing the prospective patient of their seropositive status and obtaining the patient's consent beforehand, unless the patient is unable to consent.
- HIV/HBV-positive health-care workers may perform exposure-prone procedures only if they seek counsel from an expert review panel and have been advised under what circumstances, if any, they may continue to perform the exposure prone procedure (2).

Thus, if a medical practice employs a physician or health-care worker who has been diagnosed as HIV-positive, that person's situation would need to be reviewed by an expert review panel. The review would be instrumental in determining whether informing patients of the physician's or health-care worker's seropositive status is necessary before he or she can perform certain procedures.

Q: Exactly which procedures are "exposure prone"?

A: This is a controversial area. The Centers for Disease Control used the term "exposure-prone procedures" in the July 11, 1991, guidelines, but that term has been dropped at the urging of the American Medical Association in favor of "procedures that pose a significant risk of trans-

mission." Nevertheless, Texas law retains the term "exposure-prone procedures."

Semantics aside, the general consensus has been that there is not sufficient scientific data to develop such a "list" of such procedures, although the following procedures are known by the CDC to have been involved in hepatitis B transmission from physician to patient:

- intra-abdominal and colorectal surgery;
- intrathoracic surgery, including cardiac surgery;
- major orthopedic surgery;
- major gynecological surgery;
- cesarean deliveries and vaginal deliveries requiring suturing; and
- surgery in the oral cavity.

Physicians would be well advised to check with the appropriate medical specialty society or hospital medical staff committee to see if they have identified any other procedures.

The bottom line with regard to Texas law is this: use universal precautions; determine whether the physician or health-care worker will be performing any procedures identified as risky, and, if so, have the HIV-positive person reviewed by an expert review panel; and obtain informed consent from the patient before performing "exposure-prone" procedures.

Q: Which employers are affected by the Americans with Disabilities Act?

A: Title I of the ADA deals with employment discrimination. On July 26, 1992, Title I became effective for those employers with more than 24 employees. For those with 15 to 24 employees, Title I becomes effective July 26, 1994. Title I does not affect employers with less than 15 employees.

Under Title I, an employer may not discriminate against a "qualified person with a disability" in any phase of employment, including job applications, hiring, firing, advancement, compensation, and training.

Q: Who is regarded as disabled under the ADA?

A: A person has a "disability" if he or she meets the following three-part test:

1. a physical or mental impairment that substantially limits one or more major life activities of the person;
2. a record of such an impairment; or
3. being regarded as having such an impairment.

A person with HIV-infection *is* considered disabled.

HIV/HBV-positive health-care workers may perform exposure-prone procedures only if they seek counsel from an expert review panel . . .

Q: What does it mean to make a "reasonable accommodation" for a disabled worker?

A: There are several aspects to this. A "reasonable accommodation" must be an *effective* accommodation, but need not be the *best* accommodation. An employer is not required to provide an accommodation that is primarily for personal use. The accommodation obligation applies only to reducing barriers to employment related to a person's disability, although an employer may go beyond the ADA in making an accommodation.

Examples of reasonable accommodation include:

- making existing facilities accessible;
- job restructuring, such as reallocating nonessential, or "marginal," functions to other employees;
- part-time or modified work schedules; and
- reassignment to a vacant position if reasonable accommodation is not possible in the employee's current position. The transferred employee must be able to perform the essential job functions of the job to which he or she is transferred with or without reasonable accommodation.

An applicant or employee has an absolute right to refuse a reasonable accommodation offered by an employer even though doing so might take the applicant out of the pool of qualified applicants.

Q: But what if accommodating the HIV-infected worker presents a hardship?

A: A reasonable accommodation is one that can be adopted without "undue hardship," which the ADA defines as an "action requiring significant difficulty or expense." The Equal Employment Opportunity Commission interprets this to mean any action that may be unduly costly, be extensive, be substantial, be disruptive, or fundamentally alter the nature or operation of the business. The employer bears the burden of persuasion that an accommodation would result in an undue hardship. It is unclear how arguments that the accommodation will result in a burden on coworkers will play. A negative impact on morale may not be a factor to be considered, but a heavier workload is.

Q: What if an employer believes that an HIV-infected health-care worker threatens patient safety? Can that worker be reassigned or discharged?

A: An employer's discrimination against a disabled worker violates the ADA unless the employer can prove *either*:

- the worker cannot presently perform the essential job functions, with or without reasonable accommodation; or
- the worker cannot perform the essential job functions without posing a "direct threat" of injury to himself or others.

A direct threat means a "significant threat" to the health and safety of others that cannot be eliminated or reduced by reasonable accommodation. To consider whether a direct threat exists, the law looks at:

- the duration of the risk;
- the nature and severity of the potential harm;
- the likelihood that the potential harm will occur; and
- the imminence of the potential harm.

Thus, under the ADA, no employer is required to hire a disabled applicant including an HIV-infected health-care worker, if:

- he/she cannot perform the essential functions of the position, with or without reasonable accommodation;
- he/she cannot be reasonably accommodated without undue hardship; or
- he/she cannot perform the essential job functions without posing a "direct threat" of injury to himself or others.

In line with this, you may want to order the Equal Employment Opportunity Commission's ADA Technical Assistance Manual for Title I. It costs $25 and is available from: Superintendent of Documents, PO Box 371954, Pittsburgh, PA 15250-7954.

Q: What directions have the courts taken on this issue?

A: There are no ADA cases yet, though there are cases under the federal Rehabilitation Act of 1973 and other laws that are worth reviewing.

Q: Can a hospital require disclosure of a health-care worker's HIV test results?

A: In *Leckelt v Board of Commissioners* (909 F2d 820, 5th Cir 1990), the appeals court held that a hospital could require a nurse to reveal results of an HIV test he had voluntarily taken and, when he failed to do so, could prevent him from working and ultimately terminate him. The hospital had reasonable cause to believe the nurse was infected because the nurse's "lover" had died of AIDS-related causes.

The appeals court found the nurse not to be protected under the Rehabilitation Act of 1973. The hospital was found to have terminated the nurse not because it believed the nurse was HIV-infected but because the nurse violated an existing hospital policy for reporting infectious diseases.

The court looked at existing (pre-1991) Centers for Disease Control guidelines and stated that the recommendation that health-care workers be evaluated on a case-by-case basis could not be fulfilled without knowledge of the nurse's HIV status. The worker's refusal to submit HIV test results prevented the hospital from deciding what, if any, control measures were necessary to protect the health of this nurse, the hospital's patients, or other employees. Thus, the nurse was not "otherwise qualified" under the act. The appeals court also held that no invasion of privacy claim arose since the nurse had a "significantly diminished" expectation of privacy of the HIV test results under the circumstances of the case.

This case has been cited to present the idea that an infectious disease reporting policy will probably support requiring employees to disclose their own HIV status under the Rehabilitation Act of 1973 and possibly the Americans with Disabilities Act as well.

Q: Can a hospital restrict privileges of HIV-infected physicians?

A: In *Estate of Behringer v The Medical Center at Princeton* (New Jersey Superior Court, no. L88-2550, April 25, 1991), a hospital learned that an ENT surgeon had AIDS and summarily suspended his surgical privileges. Later the hospital allowed him to perform surgery only if patients signed an informed consent form. Next, the hospital adopted a policy prohibiting all HIV-infected physicians from performing procedures that pose "a risk" of transmission unless written informed consent was obtained.

The trial court held that even if procedures pose only a "tiny risk" if no break in infection control procedures occurs, the HIV status of a physician is "material" information from an informed consent standpoint because an exposure is always possible. That exposure would subject the patient to risk of infection and to repeated HIV testing over an extended period of time with resultant disruption of lifestyle and procreation. The court acknowledged

that requiring the physician to reveal his HIV status in a consent form to be signed by the patient would be a de facto termination of surgical privileges, but concluded that the patient's rights must prevail.

This case shows that courts may not accept the argument that the threshold determination for informed consent purposes is a "substantial risk" under the Americans with Disabilities Act or CDC guidelines.

Q: What about disclosure of the HIV test results of medical residents?

A: In *In re application of Milton F. Hershey Medical Center of Pennsylvania State University* (Pennsylvania Superior Court, July 30, 1991), the trial court ordered the name of an HIV-infected resident be disclosed to physicians in the obstetrics and gynecology department and to any physician authorized in writing by a patient for whom the resident had participated in a surgical procedure or obstetrical care. Each physician to whom the resident's name was disclosed was to be "reminded" that state law prohibited redisclosure.

The trial court rejected the resident's argument that disclosure would curtail voluntary testing by health-care workers and held that disclosure would not violate state confidentiality laws because the hospital showed a "compelling need" to disclose the information. The "compelling need" apparently consisted of an argument that "possibly infected" patients should be informed of potential exposure and offered testing, treatment, and counseling. The trial court also held that other physicians should know the resident's name so they could alert their patients of a potential exposure risk. Finally, the disclosure was found necessary to protect other health-care workers from being stigmatized and alleviate any "mass hysteria" that could result from a more general disclosure.

Q: Can patients sue for fear of AIDS if they learn a physician's serostatus?

A: In *Rossi v Estate of Rudolph Almaraz* (1991 AIDS Litig Rptr 5702), a woman and her husband sued the estate of a surgeon who died of AIDS-related causes and the hospital where he practiced. The suit sought $32 million in compensatory damages and alleged that when they learned of a potential exposure, they suffered "extreme fear and anxiety." The case was dismissed.

The court stated that the fear of contracting AIDS as the result of treatment by an HIV-positive surgeon was not enough to merit damages, since nothing occurred during the surgery that would lead the plaintiff to think that she came into contact with the surgeon's blood. Thus, there was no reasonable basis for her to fear an HIV infection.

. . . the fear of contacting AIDS as the result of treatment by an HIV-positive surgeon was not enough to merit damages . . .

Q: Can a hospital refuse to hire an HIV-infected health-care worker?

A: Not without substantial legal risk. In *In the Matter of: Westchester County Medical Center* (DHHS Departmental Appeals Board 91-504-2, April 20, 1992), the defendant hospital offered an HIV-infected pharmacist employment with only limited duties. A complaint was brought. It was held that the pharmacist was protected under the Rehabilitation Act of 1973, since his infection is a physical impairment and substantially impairs his ability to perform major life activities, such as procreation and sexual conduct. Because the hospital denied the disabled pharmacist the opportunity to perform the full range of pharmaceutical duties, it discriminated against him solely by reason of his handicap.

Furthermore, because the defendant hospital received at least 40% of its funds from Medicare/Medicaid, denial of federal funds was a proper remedy for the discrimination that was not limited to the individual pharmacist, but was part of the hospital's policy of discrimination against HIV-infected employees in the terms and conditions of employment.

This was a case under the ADA's predecessor law, the Rehabilitation Act of 1973. Since cases under the predecessor law will be used as precedent under the ADA, the implications are ominous. Also ominous is the denial of federal funds, which could result in quick closure of the hospital.

Q: What does the American Medical Association currently say about HIV-infected physicians?

A: At the 1992 Annual Meeting, Board of Trustees Report BB, entitled "HIV Infection and Physicians," was presented. The following language was adopted:

> *Any physician who performs patient care procedures that pose a significant risk of transmission of HIV infection should voluntarily determine his/her serostatus at*

intervals appropriate to risk. The periodicity will vary according to circumstances of the individual, and that judgment should be made at the local level.

Furthermore, the AMA reaffirmed previous policies and remains opposed to mandatory testing and opposed to HIV testing as a condition of medical staff privileges.

Q: What position has the Federation of State Medical Boards taken?

A: On October 4, 1991, the federation adopted a policy statement recommending that state medical boards:

1. have the power to require that physicians doing exposure-prone procedures as defined by the CDC know their HIV and HBV status;
2. have the power to require reporting of HIV- and HBV-infected physicians;
3. ensure the confidentiality of HIV- and HBV-infected physicians;
4. establish practice guidelines for HIV- and HBV-infected physicians;
5. monitor the practices of HIV- and HBV-infected physicians; and
6. discipline HIV- and HBV-infected physicians who violate laws preventing HIV/HBV transmission to patients.

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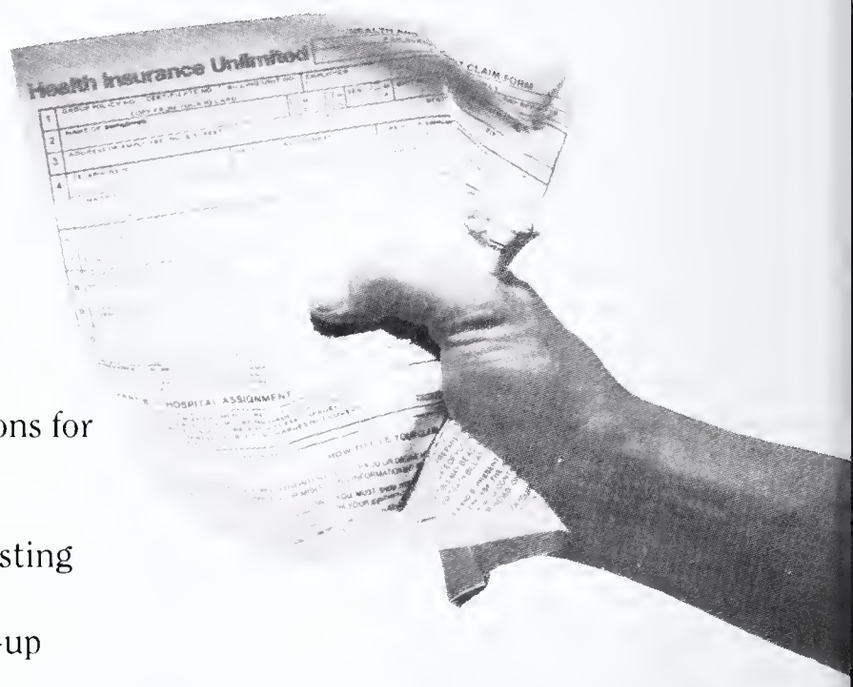

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

Approaching families for organ donation: physicians are willing

Marsha H. Exley, BSN, RN, CPTC
Mary F. Serbin, BSN, RN, CPTC
Robert M. Goldstein, MD

While current literature documents a critical disparity between the increasing demand for organs for transplantation and the relatively static supply, reasons for the shortage of donors are not well understood. Public opinion surveys describe a population willing to donate, but consent rates reported by organ procurement organizations suggest problems in the process of approaching families. This study of Texas physicians regarding their knowledge of laws related to brain death and to routine inquiry for organ donation and their attitudes toward the critical step of seeking consent from families indicates that physicians need more information about questions asked by families, would benefit from more structured hospital policies on routine inquiry, feel that physicians rather than nurses should approach families, and believe that the public is not well informed about donation.

Ms Exley, hospital development coordinator, Southwest Organ Bank, Inc, 3500 Maple Ave, Suite 800, Dallas, TX 75219; Ms Serbin, hospital development coordinator, Northwest Organ Procurement Agency, Seattle, Wash; and Dr Goldstein, assistant director of transplant surgery, Baylor University Medical Center, Dallas. Send reprint requests to Ms Exley.

Ample evidence in professional health literature underscores the escalating shortage of organs for transplantation (1–3). With dramatic increases in the success rate of solid organ transplantation since the Federal Drug Administration's approval of cyclosporine, an effective immunosuppressive drug, recipient waiting lists have blossomed as additional diseases are now being treated by transplantation rather than traditional medical therapies. In an effort to correct this gaping supply-demand disparity, the federal government enacted legislation (PL 99-509) in 1987, which mandates that families of deceased in-hospital patients be approached, when appropriate, with the option to donate organs and tissues. The Texas version of this law, known as "Routine Inquiry," went into effect January 1, 1988. These laws were expected to address the underlying assumption that willing families were not being offered the donation option. Paradoxically, donation rates declined in 1987 and have only risen in small increments since then, thus widening the supply-demand gap. As of November 30, 1991, there were 1,209 Texans waiting for organs, according to the United Network for Organ Sharing (UNOS). To explore the various reasons for the shortage of organ donors hypothesized in the literature, Southwest Organ Bank in conjunction with the liver transplant program at Baylor University Medical Center conducted a survey of Texas physicians in 1989.

METHODS

A 12-item anonymous questionnaire consisting of multiple-choice, scaled-response, and open-ended questions was mailed to a randomized sample of 1,650 Texas physicians (Fig 1). The sample consisted of doctors likely to encounter brain-dead patients by practicing in specialty areas such as anesthesia, emergency medicine, family practice, general and vascular surgery, neurology, and transplant surgery. Neurosurgeons were not included in the sample because they were being surveyed nationally by the Education Department of the United Network of Organ Sharing. Of the 1,650 questionnaires sent, 242 were returned, yielding a response rate of 15% and thus restricting our ability to generalize from the findings. No repeat mailing was sent and no follow-up phone calls were made to nonrespondents. Data were analyzed by frequency response.

RESULTS

Support

The physicians who responded generally supported organ donation: on a scale ranking "7" as supporting organ donation "very much," 93% scored above the midpoint. Only 20.3% reported more than "a little" experience in talking with families about organ/tissue donation; however, 80% said that they feel comfortable offering the option of donation. The physicians responded that 69% of them would feel more comfortable bringing up the issue of donation if they knew more about the questions families usually ask about the donation process.

Approach

The most surprising information came from the responses to the question of who should be designated to approach families (designation is mandated by hospital policy). Of the

Fig 1. Physician survey.

1. Do you know that Texas state law requires that families of deceased patients be approached about organ/tissue donation?
   yes _____ no _____
2. Do you support the concept of organ donation?
   not at all 1 2 3 4 5 6 7 very much
3. Have you had any experience talking with families about organ/tissue donation?
   none _____ little _____ a lot _____
4. Do you feel comfortable talking with families about organ/tissue donation?
   yes _____ no _____
5. If you knew more about the questions families usually ask about organ donation, would you feel more comfortable bringing up the issue?
   yes _____ no _____
6. Who do you think should be designated to approach families about organ/tissue donation?
   a. the attending physician _____
   b. the consulting neurosurgeon _____
   c. the chaplain _____
   d. the nurse caring for the patient _____
   e. the nursing supervisor _____
   f. the on-call organ recovery coordinator _____
   g. other _____
7. What, in your opinion, is the reason for the imbalance in supply/demand of organs for transplantation?
   a. people do not want to donate _____
   b. no one is asking the families _____
   c. the state laws (required request) need to be enforced _____
   d. hospitals do not have policies/procedures _____
   e. other _____
8. How many potential donors occur at your hospital per year?
   a. potential donors? Never
   b. maybe 1–2 per year
   c. more than 3 potential donors
9. Do you know what the brain death policy is at the hospital(s) where you practice?
   yes _____ no _____ there is none _____
10. Do you feel (understand and agree with) comfortable with the criteria for brain death determination?
    yes _____ no _____
11. What educational modality would you favor for learning more about organ/tissue donation/transplantation?
    a. seminar _____
    b. speaker at medical meeting _____
    c. workshop in Hawaii _____
    d. other _____
12. What topics would you benefit from learning more about?
    a. brain death determination _____
    b. family approach _____
    c. clinical management of the potential donor _____
    d. evaluation of potential donors _____
    e. economics of organ transplantation _____
    f. ethics of organ transplantation _____

Additional comments

_____

_____

Optional:

Specialty: _____

Hospital: _____

Name: _____

respondents, 80.2% felt that the attending physician should be designated; nearly 29% would include the organ recovery coordinator as a designated requestor. What is remarkable is that only 10% of the respondents chose the attending nurse as an appropriate person to approach the family for donation, and only 1.3% of the surveyed physicians felt that the nurse alone was the most appropriate person to ask the family (Table 1).

Supply-demand imbalance

The question of possible reasons for the supply/demand imbalance yielded the following, in order of response: families are not being asked (54.5%), people do not want to donate (47.1%), hospitals do not have policies or procedures (23.6%), and "other" — public is not informed or educated.

Brain death

Two survey questions pertained to criteria for brain death. These questions dealt with knowledge of the policies regarding brain death at the hospitals with which the physicians were affiliated and dealt with their comfort with the criteria for brain death. Of the respondents, 65% knew of their hospital's policy and 86% reported being comfortable with the criteria; however, when asked which topics they felt they could benefit from learning more about, almost 40% said determination of brain death (Table 2).

DISCUSSION

Physicians as a group are very supportive of organ donation and carry signed donor cards with greater frequency than the general public (1). Support, however, does not necessari-

Table 1. Physicians' responses* showing who should be designated to approach families about organ/tissue donation (n = 242).

Designated Individual	Responses (%)	
	Jointly	Alone
Attending physician	80.2	41.8
Consulting neurosurgeon	13.6	0.8
Chaplain	25.6	1.3
Nurse caring for the patient	10.3	1.3
On-call organ recovery coordinator	28.9	8.0

*Respondents could choose any of the above.

ly translate into willingness to become involved in this emotionally demanding activity. In a recent study of physician attitudes in Minnesota (2), reluctance to approach families about donation was examined and scaled. The most common reservation was a hesitation to impose on the family at such a time, followed by uncertainty about what to say and how to say it, and discomfort with the diagnosis of brain death. Current data (3) on the psychological and behavioral factors influencing willingness to donate organs indicate, however, that the public does *not* view the subject of donation as an imposition. Further, the data demonstrate that the single most important determinant of willingness to donate the organs of next of kin is prior knowledge that the deceased wanted to be a donor. Few people, according to these studies, are willing to go against the expressed wishes of the deceased, regardless of their own attitudes toward organ donation.

A misconception about public attitudes toward donation appears to be one deterrent to physician involvement in the family discussion. Nonetheless, doctors overwhelmingly agree that the attending physician should approach a deceased patient's next of kin with the option to donate organs, despite the fact that physicians receive no particular training for this admittedly difficult and emotionally charged task. Most physicians say they would benefit from information about the usual concerns of families in this situation as well as from specific guidelines about what to say and how to say it (2). To date, however, no formal mechanism (eg, in medical school) exists to provide this information and training. Informal in-services are usually poorly attended.

Historically, organ procurement organizations have concentrated their educational efforts on critical care nurses. Educational programs, symposia, and, more recently, workshops for requestors have targeted critical care nurses. Postdonor-recovery conferences conducted routinely by Southwest Organ Bank to "de-brief" the intensive care unit and operating room nurses after donor cases demonstrate experientially the important role of nurses in approaching the family, evaluating and managing the donor, and assisting in the surgical removal of the organs. Yet, physicians dramatically deemphasize the role of nurses, especially in approaching the family. A landmark study of nurses' perceptions of cadaver organ procurement (4) revealed that although they are usually the first to identify potential donors, 79% of nurses reported that the family is approached by the physician. Retrospective reviews of death records conducted in 1990 at 20 hospitals serviced by Southwest Organ Bank (unpublished data) revealed that physicians approached families for organ donation 68% of the time. These findings indicate that physicians are truly the key to this crucial aspect of the donation process.

The other major factor in the supply-demand equation is brain death. Texas state law offers no criteria for determination of brain death other than complete irreversible cessation of all brain function, including the brain stem. This determination may be made by any licensed physician; testing methods are set by hospital policy. Findings of our survey, supported by current literature, indicate continuing confusion among medical professionals about the criteria for determining brain death and attendant discomfort in explaining brain death to families of potential donors whose hearts beat, chests rise, and who may exhibit disturbing movements from spinal reflexes (5). Adding to this confusion are the references to "life support" machines, prolonging "life" for organ donation, and, occasionally, the erroneous documenting of the time of "death" as the moment the machines are turned off in the operating room.

CONCLUSIONS

Physicians, by their own report, support organ donation and perceive

Table 2. Physicians' responses* showing what topics they would benefit from learning more about (n = 242).

Topic	Responses (%)
Determination of brain death	39.7
Family approach	48.3
Clinical management of the potential donor	56.6
Evaluation of potential donors	47.5
Economics of organ transplantation	36.4
Ethics of organ transplantation	33.5

*Respondents could choose any of the above.

themselves to be in the primary roles of donor identification and approach to families. Yet, to date, medical education and training in both areas have been woefully inadequate. The profound shortage of donated organs for transplantation must eventually dictate changes in the education and training of physicians, because they are indeed the key to the equation of supply and demand.

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Health expenditures in Texas, 1988

Charles E. Begley, PhD
Jeffrey J. Guidry, MPA

Expenditures for health care in Texas during 1988 totaled $32.4 billion. Health spending by category of service and sources of payment was estimated and compared with estimates for prior years and with national trends. Texas differed from the nation as a whole in average annual increases in total spending, the percentage of spending for prepayment and administration, and the percentage of spending paid by consumers, the federal government, and private insurance. Proposed expansions in insurance coverage for the large proportion of uninsured Texans will probably require strong efforts to contain costs.

Dr Begley, associate professor of management and policy sciences, School of Public Health, The University of Texas Health Science Center at Houston, 1200 Herman Pressler, PO Box 20186, Houston, TX 77225; Mr Guidry, research associate, School of Public Health, The University of Texas Health Science Center at Houston. Send reprint requests to Dr Begley.

Total spending and sources of payment for health care in Texas for the year 1988 were estimated and compared with estimates for prior years and with national trends. Definitions of categories of spending and methods for estimating each category were based, as much as possible, on the annual accounting of national health expenditures published by the Office of National Cost Estimates of the Federal Health Care Financing Administration (HCFA) (1). Like the national reports, our estimates comprise eight categories of spending for personal health care and three categories for nonpersonal health care.

State-specific sources of data were used in estimating spending for hospital, physicians' services, and dental services, which together account for more than 70% of total personal health-care spending. Estimates for other professional services, drugs and drug sundries, eyeglasses and appliances, nursing home services, and other health services are projections based on per capita spending at the national level. Among the nonpersonal items, prepayment and administration as well as government public health activities were estimated independently; the projection for research and construction was based on that category's proportion of total spending at the national level.

State government spending on health, including the cost of professional education and research, was estimated separately. We used a two-step process. First, all health-related spending by the state government was identified from *Legislative Budget Estimates* (2) prepared by the Legislative Budget Board and from the annual reports of various agencies. Second, the expenditures were then allocated to the HCFA categories based on type of service. A definition of each category of service and more detailed explanation of the methods used to estimate both total and state government spending have been published previously (3).

Total expenditures by category of service

In Texas, expenditures for health in 1988 totaled $32.4 billion, an increase of 133% since 1980 (Table 1). The average annual increase in health spending was 11.2% during this period, slightly higher than the national average of 10.7%. As a percentage of total state product (the value of all goods and services sold during the year), health care rose by almost 3.3% from 1980 through 1988. Total expenditures for personal health in Texas rose from $27.3 billion in 1987 to $29.5 billion in 1988; comparable expenditures in the country rose from $442.6 billion to $478.3 billion.

The consumer price index rose 4.7% per year over the period, accounting for a little more than one third of the increase in health spending (37.6%). About one fourth (24.8%) of the increase can be attributed to population growth. The remaining (52.4%) increase resulted from factors within the medical marketplace, including rises in medical prices that exceeded the general price index, increases in utilization (people using more medical services), and increases in intensity (medical services using more expensive resources).

Health spending is growing more rapidly than the general economy. The 1988 percentage of Total State Product devoted to health (Table 1) indicates that the health-care indus-

Table 1. Texas spending for health care by category of service, 1980 through 1988. Amounts spent expressed in billions of dollars.

	1980	1981	1982	1983	1984	1985	1986	1987	1988
Personal health care	12.60	14.75	17.30	19.54	21.59	23.20	25.37	27.34	29.51
Hospital care	5.45	6.55	7.86	8.84	9.54	10.28	10.97	11.77	12.91
Physicians' services	3.01	3.60	4.30	4.87	5.42	5.73	6.37	6.79	7.00
Dental services	0.79	0.91	1.05	1.20	1.40	1.36	1.56	1.62	1.77
Other professional services	0.31	0.33	0.35	0.49	0.58	0.64	0.72	0.79	1.11
Drugs and drug sundries	1.28	1.42	1.58	1.77	2.02	2.25	2.47	2.73	2.88
Eyeglasses and appliances	0.33	0.35	0.38	0.44	0.52	0.60	0.69	0.79	0.81
Nursing home services	1.12	1.23	1.36	1.48	1.60	1.77	1.94	2.15	2.25
Other health services	0.31	0.36	0.42	0.45	0.51	0.57	0.65	0.70	0.78
Prepayment and administration	0.84	1.14	1.14	1.35	1.82	1.79	1.49	2.04	1.16
Government public health activities	0.28	0.32	0.36	0.40	0.42	0.44	0.49	0.52	0.55
Research and construction of medical facilities	0.69	0.78	0.87	0.96	1.01	0.98	1.02	1.06	1.19
Total	14.41	16.99	19.67	22.25	24.84	26.41	28.37	30.96	32.41
Annual growth rate (%)	13.8	17.8	15.7	13.2	11.6	6.4	7.4	9.1	8.4
Percent of Total State Product	7.3	7.1	7.7	8.3	8.5	8.6	8.9	9.75	10.57

try accounts for more than $1 out of every $10 of economic activity in the state. The Texas percentage was slightly smaller than the national average (11.1% in 1988), but the gap appears to be decreasing. Since 1980, the Texas percentage grew by 0.41% per year, while at the national level the percentage grew by 0.25% per year.

Hospital care continued to be the most expensive service for health in the state, absorbing 38.5% of total costs in 1988 (Table 2). Physicians' services were second (20.9%), followed by drugs and drug sundries (8.6%) and nursing home services (6.7%). The relative proportion of spending by category of service has remained fairly stable since 1980, indicating that health expenditure increases have occurred across all types of service.

On a per capita basis, Texans spent $1,930 in 1988, about twice the 1980 amount (Table 3). Compared with national expenditures, Texans spent slightly less per person throughout the 1980 through 1988 period: 95.0% in 1980, 97.3% in 1984, and 94.2% in 1988. The difference is accounted for primarily by government public health activities (52.4% of the 1988 national average) and nursing home services (81.7% of the 1988 national average). Per capita spending in other categories was roughly similar to that of the nation except for prepayment and administration, which was well below the national average in 1988 but above the average in 1984 and 1980.

Texas differs from the United States as a whole with respect to the distribution of health financing. A higher percentage of payment comes directly from consumers and a lower percentage from the federal government and private insurance (Table 4).

Note that the Texas percentages for private insurance coverage are influenced by our estimate of the proportion of total private insurance provided directly by businesses (the self-insurance rate). Widely varying estimates of this rate are available from the State Board of Insurance (30% in 1986) and Blue Cross/Blue Shield of Texas (63% in 1990). The figure for 1987 in Table 4 is based on a 30% self-insurance rate. The figure for 1988 is based on a 50% rate.

The percentage of total spending financed by consumers and other sources was about 8% higher in Texas than in the nation on the average. Consumer sources, which account for 90% of this category, refer to the out-of-pocket payments made by individuals at the time goods or services are received. Out-of-pocket payments result when consumers lack coverage by private insurance for medical costs and are ineligible for public insurance programs (primarily Medicare or Medicaid). Texas has one of the highest proportions of noninsurance in the country. Several possible reasons may explain the higher proportion of uninsured Texans. Texas has a relatively large service sector and other industries (agriculture, mining, construction, and transportation) with lower insurance coverage; the relatively small manufacturing sector typically carries more insurance. The state's relatively large percentage of low-income families tend to be uninsured. Texas also has a higher percentage of young adults, minorities, and persons with less than a high school education, who tend not to be insured.

The lack of federal dollars for health care may be attributed to two

Table 2. Distribution (%) of Texas spending by category of service, 1980 through 1988.

	1980	1981	1982	1983	1984	1985	1986	1987	1988
Personal health care	87.38	86.83	87.95	87.80	86.92	87.83	89.42	88.29	89.04
Hospital care	37.83	38.54	39.97	39.73	38.41	38.90	38.66	38.00	38.46
Physicians' services	20.86	21.18	21.89	21.87	21.82	21.68	22.46	21.92	20.85
Dental services	5.49	5.36	5.32	5.40	5.62	5.14	5.48	5.24	5.27
Other professional services	2.17	1.94	1.77	2.20	2.34	2.44	2.55	2.55	3.31
Drugs and drug sundries	8.89	8.38	8.04	7.96	8.14	8.50	8.72	8.83	8.58
Eyeglasses and appliances	2.26	2.07	1.93	1.99	2.09	2.28	2.43	2.55	2.41
Nursing home services	7.74	7.24	6.90	6.63	6.44	6.71	6.84	6.93	6.70
Other health services	2.14	2.12	2.13	2.02	2.06	2.18	2.28	2.27	3.46
Prepayment and administration	5.85	6.70	5.82	6.09	7.32	6.79	5.26	6.59	5.78
Government public health activities	1.96	1.87	1.81	1.80	1.69	1.67	1.72	1.70	1.63
Research and construction of medical facilities	4.80	4.60	4.42	4.31	4.07	3.72	3.60	3.42	3.54

Table 3. Per capita spending for health care in selected years, Texas vs United States.

	Texas ($)			United States ($)		
	1980	1984	1988	1980	1984	1988
Personal health care	877	1,342	1,757	934	1,389	1,868
Hospital care	379	593	769	432	638	833
Physicians' services	209	337	417	199	304	418
Dental services	55	87	105	65	100	116
Other professional services	22	36	66	24	44	89
Drugs and drug sundries	89	126	172	80	108	169
Eyeglasses and appliances	23	32	48	22	29	42
Nursing home services	78	99	134	87	129	164
Other health services	22	32	46	25	37	37
Prepayment and administration	59	113	69	39	89	103
Government public health activities	20	26	33	31	45	63
Research and construction of medical facilities	48	63	71	51	65	76
Total	1,004	1,544	1,930	1,055	1,588	2,110

Table 4. Source of funds for personal health expenditures, 1988.

	Texas Health Expenditures (%)		U.S. Health Expenditures (%):	
	1987	1988	1987	1988
Federal	22.7	22.1	30.1	30.0
State and local	10.5	11.8	10.8	10.6
Private insurance	31.8	30.9	32.2	32.5
Consumer and other	35.0	35.3	27.0	27.0

Table 5. Percentages of Texas state government expenditures for health by category of service, 1984 through 1988.

	1984	1985	1986	1987	1988
Personal Health Care	69.43	69.93	71.04	71.66	72.09
Hospital care	34.72	34.56	36.61	35.26	35.52
Physicians' services	5.90	5.36	4.14	4.53	4.69
Dental services	0.04	0.05	0.05	0.05	0.05
Other professional services	5.57	7.23	8.26	9.12	9.03
Drugs and drug sundries	3.07	3.13	3.11	3.40	3.52
Eyeglasses and appliances	0.00	0.00	0.00	0.01	0.01
Nursing home services	15.29	14.09	12.76	13.26	12.68
Other health services	4.84	5.51	6.11	6.03	6.59
Prepayment and administration	5.15	4.63	3.99	4.01	3.52
Government public health activities	7.63	7.05	7.04	7.80	7.67
Education and research	17.79	18.40	17.91	16.54	16.71
Annual growth rate	9.94	9.46	1.89	2.67	10.85
Percent of total health care spending	13.17	13.55	12.69	12.09	12.36
Percent of State budget	22.08	21.67	20.07	20.22	20.75

major factors: the relative youth of the population, resulting in lower Medicare spending, and the small size of the state's Medicaid program. Texas ranks below all states in terms of Medicaid spending per capita. The Medicaid program is funded with 60% federal and 40% state dollars.

State and local goverments financed roughly equal proportions of spending in Texas and the United States over the last 2 years. In Texas, this primarily reflects local tax dollars used to support public hospitals and clinics. As indicated above, financing by the state Medicaid program is relatively small in comparison. For example, in 1983 the total amount of local tax support received by seven of the state's largest public hospitals exceeded the entire Medicaid budget for hospital care by almost 10% (4).

STATE GOVERNMENT EXPENDITURES BY CATEGORY OF SERVICE

Total spending on health care by the Texas government was $4.1 billion in 1988, representing about 12.4% of all health spending and 21% of the state budget (Table 5). These percentages have remained fairly stable over the last 5 years. The annual growth rate of government spending for the period 1980 through 1988 was 4.4%, less than one half the rate of growth in total spending for health.

Hospital care, education and research, and nursing home services are the focal points of state government's spending on health. In 1988, these three categories accounted for almost 65% of total health spending in Texas. Hospital spending by the state comes primarily through the Medicaid program ($507.4 million in 1988). The state spent an additional $278.8 million at state-supported public hospitals including John Sealy Hospital in Galveston and M.D. Anderson Cancer Center in Houston. Spending for education and research reflects state assistance to public and private medical schools, nursing schools, and other health professions programs. Most of these funds go to The University of Texas health science centers around the state. The major source of government spending on nursing home care is the Medicaid program, which spent $526.1 million on nursing home care for the aged and disabled in 1988.

DISCUSSION

To ensure the reliability of the estimates, we followed the practices of national accounting adopted by HCFA. This does not guarantee accuracy, however. The strengths and weaknesses of HCFA's estimation methods have been the subject of much debate over the years. Another test of reliability is to compare our estimates to others. Comparable estimates of personal health expenditures for 1990 were provided recently by Lewin/ICF, Inc, in a report on health spending in each of the states (4). These authors estimated total personal health spending in Texas of $37.4 billion by using a simulation model that applied national per capita spending figures by age, income, and insurance status to the socioeconomic composition of the population in the state. This compares to our 1988 figure for personal health spending of $29.4 billion. Applying the rate of growth from 1980 through 1988, we would project a spending figure of $38.0 billion for 1990. We believe that our aggregate estimates are not far from the true value, but the reader should be cautious in interpreting the more detailed figures.

Assuming our estimates are reasonably accurate and the rate of growth from 1980 through 1988 continues, Texas can expect a $78.3 billion annual health care bill by 1996. This is almost 4½ times higher than in 1980. Per capita spending will exceed $4,000, compared to $1,000 in 1980. Financing this level of spending is threatening the solvency of some employers, contributing to deficits in the public sector, and creating a heavy burden for many people. A growing consensus agrees that the current system of health-care financing and delivery that has fostered the rapid rise in expenditures must be changed but not on how to change it.

A number of proposals for reform have been put forth. These range from radical transformations of health-care financing and delivery (ie, creation of a single-payer, public insurance system like Canada's) to incremental strategies that build on the pluralistic private insurance system. Such strategies include "managed care" options that attempt to contain costs through better coordination of services and utilization review, and regulatory options such as setting hospital rates. A successful solution will have to both contain costs effectively and improve access for the millions of low-income Texans without public or private coverage for health insurance.

The recent report by the Texas Medical Association's Ad Hoc Committee on Financing and Availability of Health Insurance made a useful contribution to this debate by offering a comprehensive list of proposals addressing the problem of access for the uninsured (5). However, this report has been criticized for failing to provide concrete strategies to contain costs. Because of the strong connection between health insurance coverage and the use of medical care, expansions in private or public insurance will have a large impact on health expenditures in Texas. The fiscal situation faced by the state seems to indicate that any proposed expansions in insurance coverage be accompanied by strong efforts to ensure that health-care costs are contained.

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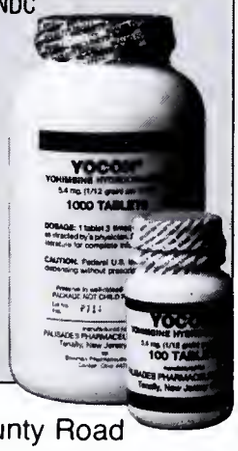

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Family/General Practice

Austin, Texas — Physician(s) needed for full time, part-time, weekdays, weekends to staff a free standing urgent care center. Remuneration commensurate with experience. Send CV and application to Austin Medicenter, c/o Sheila Twyman, Medical Administrator, 6343 Cameron Rd, Austin, TX 78723 or call 512-467-2052.

FAMILY PRACTICE

Are you ready to enjoy rural life and a two-physician practice? The Atascosa RHI Health Clinic, Inc., a federally funded community health center, located at 310 W. Oaklawn, Pleasanton, Texas, 30 miles south of San Antonio, is the place for you. If interested, please call Jaime Garcia, MD, Medical Director, or Esther Maese, Executive Director, at 512-569-2527.

Family Practice — BE/BC family physician needed to join with 4 other family practitioners in a thriving practice in Beaumont, Texas. Modern, full-service clinic offers a guaranteed salary plus percentage of production and benefits. Send CV to Nancy Bloomfield, 4010 College, Suite 200, Beaumont, TX 77707.

Family Practice — Long established and respected Houston multispecialty group is adding two family practice physicians. Excellent income and generous benefit package with partnership possibilities. Outstanding potential for professional growth. State-of-the-art facility soon to be constructed. For information, call Jerry Nisenson, 713-669-0344, 713-869-3701, or 1-800-944-4047.

1490 FP — Join two family physicians in a dynamic practice in a nice community in west central Texas. The successful candidate will want to practice the full range of medicine from pediatrics to geriatrics, including obstetrics. A new office equipped with the most modern equipment available, including x-ray, lab, ultrasound, Holter monitoring, and a minor surgical suite. A liberal compensation and benefit package is available. If you want to practice family medicine, this is the opportunity you should not overlook. For more information, call Fred Compton at 1-800-626-1857, ext 244.

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Family practitioner to practice in a community that offers small-town charm and a progressive high-tech hospital. Deep in the heart of the beautiful Texas Hill Country, New Braunfels is located 30 miles from San Antonio and 50 miles from Austin. The combination of the beautiful hill country and the close proximity to two large metropolitan areas offers unlimited opportunities for a splendid lifestyle. The candidate can expect a supportive/progressive Medical Staff, advanced high-tech equipment, and outstanding Nursing and Ancillary staff. Contact Mr Tim Brierty, Assistant Administrator, or send your CV to:

McKenna Memorial Hospital
143 East Garza Street
New Braunfels, Texas 78130
1-512-625-9111, Ext. 194

Breckenridge Family Clinic P.A. is looking for a new associate immediately. Terms are negotiable. Prefer board-certified practitioner with dedication to and interest in rural medicine. Contact W.E. Prater, MD, at 817-559-7475 (Grad UTMB '84, John Peter Smith '87) or send CV to 103 S Hartford, Breckenridge, TX 76424.

Family Practice — Join a family group in San Angelo with multiple practice options: practice in a modern facility on a prestigious Air Force base; share emergency medicine coverage in the sponsoring hospital or practice in a private office setting. This unique practice is flexible and can lead to your own private practice either in solo or with associates. With a service area of over 120,000, there are ample activities for the entire family, an outstanding university, cultural events for everyone, and abundant outdoor activities. The compensation and benefit package is excellent. There are no administrative responsibilities and no risk. For more information, please call Fred Compton at Physician Services of America, toll-free at 1-800-626-1857, ext 244.

Austin: Family Practice; Community Health Center — Immediate opportunity in Austin, Texas, for BC/BE Family Practitioner with growing, community-based practice. Primary care center provides comprehensive care to low-income children and adults, including on-site laboratory, pharmacy, and social services. Inpatient and specialty care through established referral network. Responsibilities include supervision on mid-level practitioner and participation in Center's total quality improvement program. Ability to speak Spanish highly desirable. Competitive salary and benefits. Contact David Needham, MD, Seton East Community Health Center, 512-385-4114. FAX 512-385-2079.

Scenic Colorado front range community of 30,000, with a strong, growing economic base, needs Family Physicians. Join a group of physicians or establish a solo practice with cross coverage. Full range of family medicine, including OB, available. Hospital offers generous guarantee for the physician wanting to be close to Rocky Mountain recreation as well as metropolitan areas. Call Rita Longino at 1-800-279-5267 or FAX CV to 1-800-467-1246, or send CV to WHS, PO Box 2107, Corrales, NM 87048-2107.

Family Practice Opportunity — Red River General Hospital located in northeast Texas at Clarksville seeks a physician who is interested in starting a practice in a community of 5,000 serving an area of 16,000. We are an underserved area, therefore eligible for school debt repayment. Excellent medical staff to work with, as well as a well-equipped and staffed hospital. Office, staff, and utilities provided. Guarantee more than $100,000, possibly as much as $150,000. Call Jim Luft, CEO, or Dr E.E. Brooks, Chief of Staff, for more information. 903-427-3851.

Ambulatory Care — Houston — Clinic focusing on worker's comp/personal injury needs associate. Income based on productivity; full benefits. Should make in excess of $160,000 per year. Other ambulatory care/urgent care openings also available. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911 or 713-531-0911.

General Surgery

Houston Suburb — Sudden retirement provides excellent opportunity. Join 3 solo surgeons in call group in family-oriented community north of Houston. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911.

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Gold Mine for Internist — Wanted, aggressive and energetic physician, BE/BC to do consultations for a group of family physicians. Must be able to do procedures. Very competitive fee for service income available, including benefits. Salary is based on percentage of collections with a base salary guarantee. Send CV to Nancy Bloomfield, 4010 College St, Suite 200, Beaumont, TX 77707.

Internal Medicine, Dallas, Texas — Opportunity for BC/BE general internist to join single-specialty group practice. New facility located on campus of tertiary care teaching hospital with IM residency program. Offer includes very competitive salary, attractive benefits, liberal vacation, and educational leave. Call 1-800-727-6131 for more information.

North Dallas Area — Established physician seeks partner. Exceptional opportunity for well-trained, outgoing, industrious physician seeking both a busy practice and quality lifestyle. Attractive financial package with first year guarantee — $100,000. 4-way call. Spacious, modern office adjacent to hospital campus. Call Kristin Aldrich, 1-800-533-0525, 10983 Granada, Overland Park, KS 66211.

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OB/GYN — Long established and respected Houston multispecialty group is adding two OB/GYN physicians. Excellent income and generous benefit package with partnership possibilities. Outstanding potential for professional growth. State-of-the-art facility soon to be constructed. For information, call Jerry Nisenson, 713-669-0344, 713-869-3701, or 1-800-944-4047.

OB/GYN for Dallas Suburb — Join 3 in stable group. Level II nursery with 1,000 births and medical service area of 100,000. Low Medicare, Medicaid, HMO, PPO. Call Barb Inselman at 1-800-533-0525 or mail CV to 10983 Granada #202, Overland Park, KS 66211.

Pediatrics

B/C, B/E Pediatrician needed to work in pediatric emergency room in South Texas part or full-time. Compensation excellent, $60/hour plus bonuses. For more information, write Ann Hawks, Coastal Bend Emergency Services, 3435 S Alameda, Corpus Christi, TX 78411 or call 512-855-8201.

North Dallas Area — Full/part-time pediatrician needed for busy practice in growing suburb. Warm, open atmosphere offers quality patient care with emphasis on preventive education. Call Barb Inselman at 1-800-533-0525 or mail CV to 10983 Granada #202, Overland Park, KS 66211.

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Expanding 15-Physician multispecialty group has excellent opportunity for a radiologist in friendly West Texas community of 25,000. Adjacent to a 153-bed modern hospital. Excellent guaranteed salary with no first year expenses in addition to benefits. Moving allowance also available. Direct inquiries or send CV to Gail Knous, Malone & Hogan Clinic, 1501 W 11th Place, Big Spring, TX 79720; 915-267-6361.

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Other Opportunities

Position Available — Seeking BC/BE Family Practice, General Internist, Endocrinologist, OB/GYN to join established multispecialty clinic. Excellent benefits and guarantee. Send CV to Leroy W. Kitch, Administrator, Skinner Clinic, 124 Dallas St, San Antonio, TX 78205.

Part-Time Medical Consultants — Social Security Administration, Disability Programs is accepting applications for part-time medical consultants and (1) Regional Medical Advisor in these specialties: Internal Medicine, Psychiatry (adult/child), Orthopaedics, Ophthalmology, and Pediatrics. Involves review and assessment of medical evidence in disability claims at a central location in (downtown) Dallas, Texas. No patient contact. Flexible hours 8–36 hours per week at $59.86 per hour for medical consultants and $69.87 for Regional Medical Advisor. For further information on qualifications or duties, contact Pat Kennedy, RN, Department of Health and Human Services, Social Security Administration, Disability Programs, 1200 Main Tower Bldg, Dallas, TX 75202; Phone 214-767-4281. For information regarding contracts, contact Ms Linda Washeck, Regional Contract Specialist, Department of Health and Human Services, Division of Administrative Services, Room 1290, 1200 Main Tower Bldg, Dallas, TX 75202; Phone 214-767-3221.

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EST CENTRAL TEXAS
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ARDIOLOGY

ORTH CENTRAL TEXAS
E/BC invasive cardiologist needed for associate actice in north central Texas community of proximately 21,000 (serving referral area of 206,000). egional medical center with modern facilities and uipment; all medical specialties and cardiovascular rgery back up. Area renown for recreational nenities. Easy access from Dallas/Fort Worth etropolitan area. Contact: Vicki Truitt.

AMILY PRACTICE

AST TEXAS
financially sound, 48-bed hospital seeks board rtified (or eligible pursuing certification) family ysician to establish a solo practice. Call sharing and verage is available from other family physicians in the mmunity. This beautiful rural community is a creational mecca; hunting, fishing, water sports, mping, etc. Competitive incentive package to alified physician. Contact: Barry Strittmatter.

AST TEXAS
vo board certified, recently trained family physicians e seeking additional family physician for associate actice (or solo sharing call) in small university town thin one hour of D/FW Metroplex. No OB. Great life yle among sophisticated population without the assles of, but access to, a large city. Lots of creational and social amenities. Generous incentive ckage from community hospital to qualified doctor. ontact: Barry Strittmatter.

L PASO
highly respected and well-established physician in El aso (population approximately 500,000), wishes to tire. He and the hospital with whom he is associated eek a board certified (or board eligible pursuing rtification) family physician to join him and begin to sume his large practice. Competitive benefit package qualified candidate. Contact: Barry Strittmatter.

ORTH CENTRAL TEXAS
eat location! Tremendous need for primary care! Call aring available, or bring a friend/colleague and actice together in this north central Texas community approximately 21,000 (serving referral area of 5,000). Regional medical center with modern facilities d equipment. Generous incentive package. Area nown for recreational amenities. One hour from allas/Fort Worth metropolitan area.
ontact: Vicki Truitt.

ORT WORTH
rgest family practice residency program in the country eks division director to coordinate faculty evelopment, (clinical) research and grant activities. osition encompasses teaching, patient care and dministrative responsibilities. Prefer physician with rural actice experience; board certification required. Clinical ssistant professorship appointment to major medical school; good income and benefits; little to no call. Join the team and enjoy your profession!
Contact: Vicki Truitt.

INFECTIOUS DISEASE

FORT WORTH
ID physician or internist needed to manage infectious disease service of major teaching hospital in D/FW Metroplex (100% ID practice). Service includes 10-bed inpatient infectious disease unit and outpatient infectious disease clinic; modern infusion lab. Intern and resident assigned to service. Great position; 40-hour work week and very limited call responsibility; excellent income and benefits. Contact: Jim Truitt.

INTERNAL MEDICINE

D/FW METROPLEX
BC internist needed to fill the position of Director, Department of Internal Medicine of major teaching hospital. Individual selected must possess strong administrative skills, be an effective communicator, committed to primary care medicine, dedicated to quality medical education and willing to provide some direct patient care. Five day work week, superb income, benefits and faculty appointment will be offered to qualified individual. Contact: Jim Truitt.

SOUTH TEXAS
Thirty minutes from Padre Island. IM group, specializing in critical care, seeks third compatible associate. Great climate and lifestyle. Recreational opportunities abound. Guaranteed income with high monetary potential. Contact: Barry Strittmatter.

FORT WORTH
BC internist needed to see patients in general medicine clinics and accommodate IM consultations in community based health clinics. Five-day work week, regular hours. Superb income and benefits. Great opportunity for interesting practice and excellent life style.
Contact: Jim Truitt.

NEUROLOGY

NORTHEAST TEXAS
Regional medical center serving 200,000 seeks BE/BC neurologist for practice; fee for service; shared call. Modern medical facilities. 100+ doctors in town. Progressive, family-oriented community with strong, diversified economy, excellent schools. Many social and recreational opportunities. Generous incentive package to qualified physician.
Contact: Barry Strittmatter.

OBSTETRICS/GYNECOLOGY

NORTH CENTRAL TEXAS
BE/BC OB/GYN needed for associate practice in north central Texas community of approximately 21,000 (serving referral area of 206,000). Regional medical center with ultra-modern OB facilities and equipment. Good neonatal support. Area renown for recreational facilities. One hour from Dallas/Fort Worth metropolitan area. Contact: Vicki Truitt.

ONCOLOGY

FORT WORTH
Full time medical oncology position at teaching hospital in D/FW Metroplex, clinical teaching appointment to UT medical school. Manage oncology division, develop full time oncology teaching service. Utilize modern facilities; infusion lab. Regular hours and limited call. Attractive income and benefits. Contact: Jim Truitt.

OTOLARYNGOLOGY

NORTH CENTRAL TEXAS
Regional medical center in community of approximately 21,000 (serving referral area of 206,000) seeks BC otolaryngologist. Associate or solo practice possibilities. Ultra-modern hospital facilities. Area renown for recreational facilities; easy access to D/FW Metroplex. Competitive incentive package to qualified physician. Contact: Vicki Truitt.

PEDIATRICS

NORTH CENTRAL TEXAS
Recently trained, BC female pediatrician seeks compatible associate for private practice. Four-way shared call; superb hospital facilities; Level II nursery. Competitive income and benefits. Attractive area with easy access to Dallas/Fort Worth. Contact: Vicki Truitt.

SOUTH TEXAS
Pediatric group practice. Three American-trained, board certified pediatricians seek compatible associate to join rapidly growing practice in the Rio Grande Valley. Excellent income potential in an area acclaimed for its great climate and recreational opportunities.
Contact: Barry Strittmatter.

NORTHEAST TEXAS
Dynamic group of American trained, BC pediatricians seek fourth associate for group practice in attractive community of 27,000 (referral area of 200,000). Progressive, family-oriented community with strong, diversified economy; excellent schools. Social and recreational opportunities abound. Modern hospital with Level II nursery and designated pediatric care unit. Shared call; excellent income and benefits; early partnership. Contact: Vicki Truitt.

PULMONARY MEDICINE

FORT WORTH
Immediate need for fellowship trained pulmonary medicine specialist to accommodate full time, 100% pulmonary and critical care consultative service. Teaching hospital, resident supervision. Limited weekend and evening call responsibility; coverage available from BC pulmonologist. Great opportunity for interesting practice with excellent life style. Good income and benefits. Contact: Jim Truitt.

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Physicians for Nationwide Travel. Health research organization seeks physician for National Health & Nutrition Examination Survey sponsored by the US Public Health Service. Individual will be part of a large medical team conducting health examinations in government mobile exam centers traveling to 88 areas of the US through Fall of 1994. Must be licensed in one state. One year minimum commitment and FULL-TIME CONTINUOUS TRAVEL REQUIRED. Competitive salary, paid malpractice, per diem, car, four weeks paid vacation per year, holidays, and health, life, dental, disability insurance offered. Call Beverly Geline, 1-800-937-8281, ext 8248. WESTAT, INC, Rockville, MD EOE/MF/V/H.

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For Sale — Large well-established solo family practice midway between Dallas/Fort Worth, Texas. Excellent hospital facilities nearby. MD will stay and introduce new physician, plans retirement. Reply to Ad Box 798, 401 West 15th St, Austin, TX 78701.

Houston — Quality practice with excellent medical reputation. Large patient base. Doctor retiring, will stay for transition. Located just outside metroplex. Contact Business & Professional Associates 713-782-8888. TDH1402.

Family Practice for Sale: Grossing $500K, Houston, Texas. For more information, please call Jack Clark at 713-579-2575.

Suburban Metroplex — Well established General Surgery practice is available. Collections in excess of $330,000 for 1991. Prestigiously located office is fully computerized. Thorough and generous introduction. Courteous and efficient staff will stay, if desired. For information, confidentially contact AD Box 803, 401 West 15th Street, Austin, TX 78701.

Family Practice — Seven-year-old north suburban solo practice. Well-equipped and busy. Excellent remuneration. Heavily discounted. By owner. 214-380-5424 after 6 pm. Leave message.

Practice for Sale — Solo GP's estate offering 25-year-old medical practice with fully equipped clinic in small college town, 60 miles northeast of Dallas. 214-969-5028.

Property

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Oct 1–2, 1992
Cardiology Update. Carmel, Calif. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Oct 11–14, 1992
Symposium on Echocardiography in Congenital Heart Disease. Rochester, Minn. Contact Mayo Clinic Foundation, 200 1st St SW, Rochester, MN 55903-9908 (800) 323-2688

Dermatology

Oct 14–16, 1992
Experience in MDA-ALS Clinic. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Oct 17–18, 1992
The Skin from A to Z. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

General Medicine

Oct 15–16, 1992
Disability, Chronic Illness & Access to Health Care. Houston. Contact Health Law and Policy Institute, University of Houston Law Center, Rm 104 TU2, Houston, TX 77201-6381 (713) 743-2106

Oct 24, 1992
Movement Disorders for the Practitioner. Scottsdale, Ariz. Contact Mayo Clinic, 13400 E Shea Blvd, Scottsdale, AZ 85259 (602) 391-7447

Oct 26–29, 1992
Primary Care Update. Las Vegas. Contact Interstate Postgraduate Medical Association of North America, PO Box 5474, Madison, WI (608) 257-1401

Oct 31, 1992
Diabetes Update. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Genetics

Oct 2, 1992
The Shape of Things to Come: Genetics for Clinic, Classroom & Community. Temple. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Infectious Diseases

Oct 16–17, 1992
Update in Sexually Transmitted Diseases. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Internal Medicine

Oct 30–Nov 1, 1992
Techniques of Patient Oriented Research. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Neurology

Oct 14–16, 1992
Amyotrophic Lateral Sclerosis: Research & Treatment. Houston. Contact Baylor College of Medicine, Office of Continuing Education, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

Obstetrics and Gynecology

Oct 31–Nov 1, 1992
Transvaginal Sonography. Houston. Contact Department of Education, American Academy of Pediatrics, PO Box 927, Elk Grove Village, IL 60009-0927 (800) 433-9016

Oncology

Oct 10–13, 1992
Pharmacy Symposium on Cancer Chemotherapy. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Oct 16–17, 1992
Recent Advances in the Biology & Treatment of Breast Cancer & Other Malignancies. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Oct 17–23, 1992
Symposium on Fundamental Cancer Research. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Oct 20–23, 1992
Immunobiology of Cancer Research Symposium: Molecular and Cellular Mechanisms. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Oct 30–31, 1992
Hematology & Oncology for Primary Care Physicians. Scottsdale, Ariz. Contact Mayo Clinic Foundation, 200 1st St SW, Rochester, MN 55903-9908 (602) 391-8300

Ophthalmology

Oct 2, 1992
Cataract 1992. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Otorhinolaryngology

Oct 9–10, 1992
Head and Neck Reconstruction Workshop. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Pediatrics

Oct 1–2, 1992
Perinatal Seminar. Temple. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Oct 16–17, 1992
Subspecialty Pediatrics for the Primary Care Physician. Dallas. Contact A. Webb Roberts Center for CME, Baylor University Medical Center, 3500 Gaston Ave, Dallas 75246 (214) 820-2317

Oct 23–24, 1992
Pediatric Postgraduate Course. Lubbock. Contact Office of CME, Texas Tech University Health Sciences Center, Lubbock, TX 79430 (806) 743-2929

Plastic Surgery

Oct 24–25, 1992
Laser Photocoagulation. Dallas. Contact

The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Radiology

Oct 23–25, 1992
Diagnostic Radiology Update. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Risk Management

Grand Rounds in Medical Malpractice. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518
Oct 1, 1992 — San Antonio
Oct 3–4, 1992 — San Antonio
Oct 8, 1992 — Dallas
Oct 10, 1992 — New Orleans
Oct 24–25, 1992 — Houston

From Deposition to Courtroom. Contact Texas Medical Association, 401 W 15th St, Austin TX 78701 (800) 880-1300 or (512) 370-1411
Oct 15, 1992 — El Paso
Oct 22, 1992 — Dallas

Transplantation

Oct 30, 1992
Symposium on Hepatic & Biliary Disease. Chicago. Contact Liver Transplantation Program, Rush-Presbyterian-St Luke's Medical Center, 1653 W Congress Pkwy, Chicago, IL 60612 (312) 942-6242

NOVEMBER

Computer Applications

Nov 7, 1992
GRATEFUL MED: Computer Access to Information. Austin. Contact Texas Medical Association Library, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1547

General Medicine

Nov 21, 1992
Hyperlipidemia Seminar. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Gastroenterology

Nov 20–21, 1992
Gastroenterology Update. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Gynecologic Surgery

Nov 20–21, 1992
Techniques in Gynecologic Surgery. Scottsdale, Ariz. Contact Mayo Clinic, 13400 E Shea Blvd, Scottsdale, AZ 85259 (602) 391-7447

Infectious Diseases

Nov 6–8, 1992
Infectious Disease Review. Rockville, Md. Contact Center for Bio-Medical Communication, Inc, 80 W Madison Ave, Dumont, NJ 07628 (800) 231-0389

Neurology

Nov 13–15, 1992
Update & Review in Neurology. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Obstetrics and Gynecology

Nov 3–7, 1992
Contemporary Issues & Practices in Ob-Gyn. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Oncology

Nov 6–10, 1992
International Symposium on Polyamines in Cancer. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Orthopedic Surgery

Nov 20–21, 1992
McKenzie Orthopaedics Seminar. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Otolaryngology

Nov 5–7, 1992
Otolaryngology Update. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

Nov 5, 1992
Pediatric Advanced Life Support Renewal Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Nov 6–7, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Nov 6–7, 1992
Pediatrics for the Practitioner. Irving. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Psychiatry

Nov 13–15, 1992
Group Therapy Symposium. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Risk Management

From Deposition to Courtroom. Contact Texas Medical Association, 401 W 15th St, Austin TX 78701 (800) 880-1300 or (512) 370-1411
Nov 5, 1992 — Tyler
Nov 12, 1992 — Amarillo
Nov 19, 1992 — San Antonio

Nov 21–22, 1992
Grand Rounds in Medical Malpractice. Dallas. Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042, (713) 789-6518

Surgery

Nov 13–14, 1992
Trauma/Critical Care Symposium for Primary Care. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

DECEMBER

Oncology

Dec 5, 1992
Cancer Update: Melanoma/Sarcoma. Houston. Contact The University of Texas

M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Dec 5, 1992
Laparoscopy & Thorascopy in Cancer Management. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Ophthalmology

Dec 10–11, 1992
Glaucoma Management. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Psychiatry

Dec 4–5, 1992
Hospital Psychiatry in the Year 2000. Houston. Contact The University of Texas Medical School at Houston, PO Box 20367, DCT S130, Houston, TX 77225 (713) 792-5346

Risk Management

Dec 3, 1992
From Deposition to Courtroom. Abilene. Contact Texas Medical Association, 401 W 15th St, Austin TX 78701 (800) 880-1300 or (512) 370-1411

Dec 5, 1992
Grand Rounds in Medical Malpractice. San Antonio. Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

Risk Management Seminars

The following course is sponsored by the Texas Medical Association through its Practice Management Department. All seminars, unless otherwise announced, will be held from 7 pm–10 pm. For further information, contact the TMA Risk Management Office, 401 W 15th St, Austin, TX 78701 (512) 370-1411.

Sep–Dec 1992

From Deposition to Courtroom

Sep 19 — Austin (2–5 pm)
Sep 24 — Harlingen
Oct 15 — El Paso
Oct 22 — Dallas

Nov 5 — Tyler
Nov 12 — Amarillo
Nov 19 — San Antonio

Dec 3 — Abilene

Calendar of Meetings

•Denotes Texas meeting

September

Sep 11–13, 1992, El Paso
•*Texas Society of Anesthesiologists Annual Meeting*
Contact TSA, 401 W 15th St, Ste 990, Austin, TX 78701 (512) 370-1659

Sep 19, 1992, Austin
•Texas Medical Association Fall Leadership Conference
Contact Jon Hornaday, 401 W 15th St, Austin 78701 (800) 880-1300 or (512) 370-1345

Sep 25–26, 1992, Irving
•*Texas Pediatric Society Annual Meeting*
Contact Texas Pediatric Society, 401 W 15th St, Austin, TX 78701 (512) 370-1506

Sep 27–30, 1992, Houston
•*Texas Technology Transfer Association*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Sep 29–Oct 4, 1992, Quebec
American Society of Cytology Annual Scientific Meeting
Contact Yener S. Erozan, MD, 1015 Chestnut St, Ste 1518, Philadelphia, PA 19107 (215) 922-3880

October

Oct 22–25, 1992, San Diego
American Pain Society Annual Meeting
Contact APS, 5700 Old Orchard Rd, 1st Floor, Skokie, IL 60077-1057 (708) 966-5595

Oct 31–Nov 4, 1992, Dallas
•*Pan American Medical Association Quincentenary Congress*
Contact PAMA, 3600 Gaston Ave, Ste 1051, Dallas, TX 75246 (214) 824-2087

November

Nov 1–2, 1992, Phoenix
Leukemia Society of America Symposium
Contact LSA, 733 Third Ave, New York, NY 10017 (212) 573-8484, ext 138

Nov 18–21, 1992, Houston
•*American Association for Cancer Education*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Nov 27–Dec 4, Chicago
Radiological Society of North America Annual Meeting & Scientific Assembly
Contact RSNA, 2021 Spring Rd, Ste 600, Oak Brook, IL 60521 (708) 571-2670

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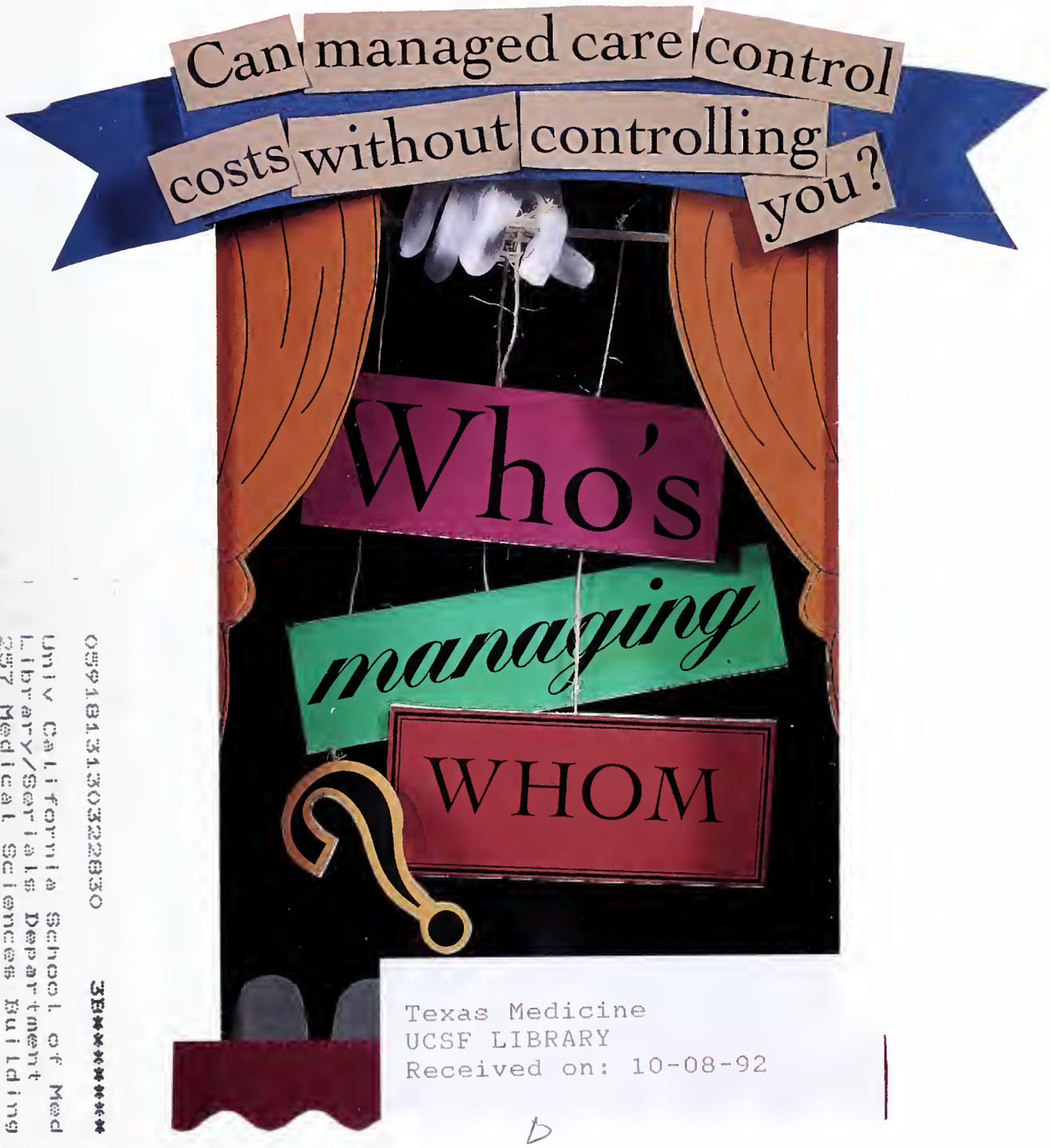

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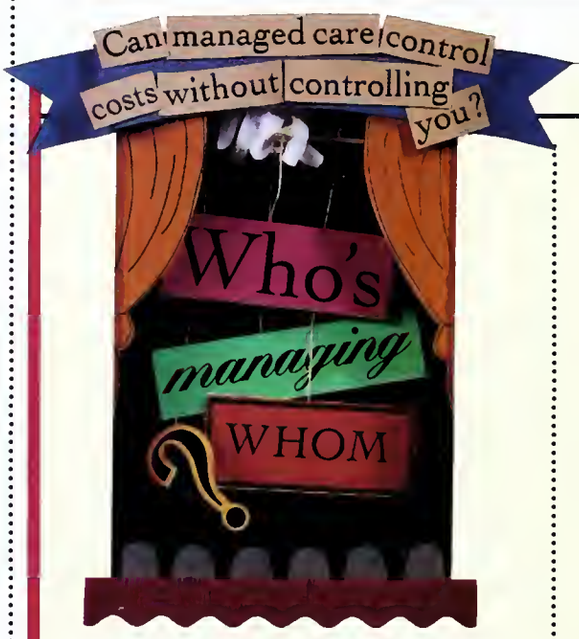

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"The majority of physicians believe that managed care plans limit their costs by limiting you . . ."
— Lane Smith, MD

Who's managing whom? Can managed care control costs without controlling you?

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•••

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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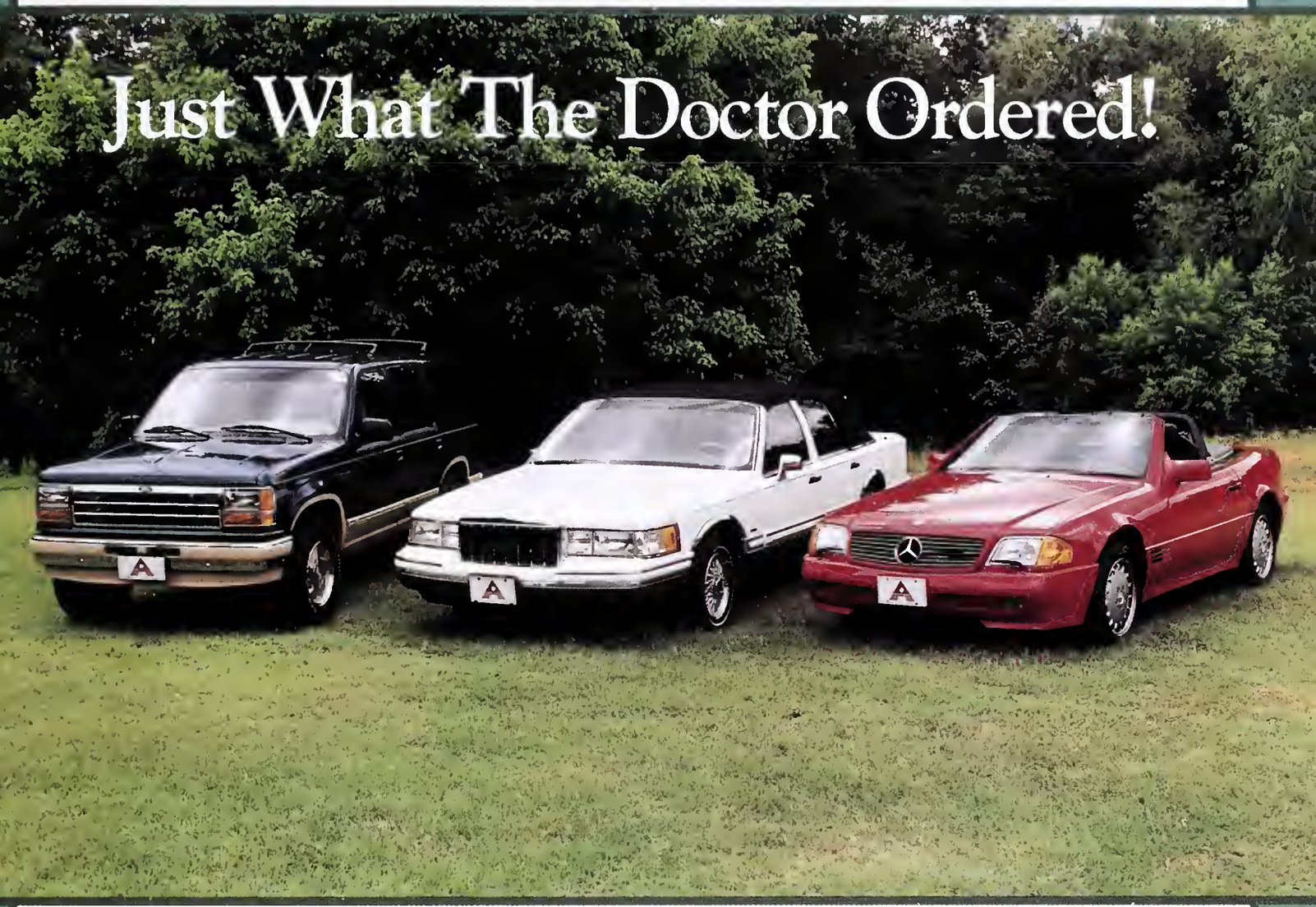

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Letters

UTHC-Tyler bolsters state's medical research effort

I WAS PLEASED WITH *TEXAS Medicine*'s effort to inform Texas physicians of the rapidly expanding medical research in our state ("Big money for big ideas: Medical research in Texas," June 1992, pp 34–41). From 1981 to 1992, Texas researchers increased their output of scientific papers by 25.3%, according to the Institute for Scientific Information, compared to an 11.7% rise for the United States as a whole.

During the same period, the research production of The University of Texas Health Center at Tyler has been even more dramatic. UTHC-Tyler is the largest medical research facility in East Texas. In fact, according to Research Expenditures of Texas Public Institutions of Higher Education, UTHC-Tyler secured $5,022,380 in total funding for medical research in 1990–1991. That would place UTHC-Tyler at No. 8 on the expenditure list published in the article. In fact, we were listed among the eight "top medical schools" in the June 25th edition of *Nature*, which highlighted science in Texas.

Our expenditures break down to $1,567,985 in federal funds, $1,694,991 in state funds, $1,259,544 in institution-controlled funds, and $499,860 in private funds. In the competitive environment that exists today for medical research dollars, we are very grateful for the grants our scientists regularly secure.

The UT Health Center at Tyler was established in 1947 by the Texas Legislature as the East Texas Tuberculosis Sanitorium. It evolved into the East Texas Tuberculosis Hospital, the East Texas Chest Hospital, and finally, in 1977, it received its present name and was transferred into The University of Texas System as the sixth health component. Its mission relates primarily to cardiopulmonary diseases and primary care postgraduate education.

Researchers at UTHC-Tyler tackle some of the most prevalent of today's health problems including cancer prevention, clotting and lung disease, lung infection, inhaled agents, and cellular lung damage. We have researchers participating in the Human Genome Project, and UTHC-Tyler was the first laboratory to demonstrate the effectiveness of the antibiotic, clarithromycin, to combat certain mycobacterial skin and lung infections. Plus, in January, four of our researchers were awarded the health center's first patent for the discovery of agents that might control the IL-8 protein, which can cause potentially harmful inflammation.

The commitment in Texas to medical research has never been stronger nor have the results been greater than today. Perhaps with more media attention, it will no longer be a secret that medical research promotes both patient care and economic recovery through the hundreds of millions of dollars that flow into the state via the public and private grants.

George A. Hurst, MD
Director
The University of Texas Health Center at Tyler
PO Box 2003
Tyler, TX 75710

Baylor Research Institute also adds to research effort

I READ WITH INTEREST YOUR article, "Big money for big ideas," and can echo many of the comments of my colleagues at academic institutions. In the competition for funding, biomedical research has been and continues to be very strong and Texas' success continues to grow.

It might interest your readers that the Baylor Research Institute of the Baylor University Medical Center in Dallas has 65 research programs that represent more than $5 million of funded research in areas of digestive disease, cancer, organ transplant, photobiology, orthopedics, metabolic disease, and virology. The Baylor Research Institute oversees the activity of 32,000 sq ft of space dedicated to medical research. We are very proud of our accomplishments, particularly in view of our 8 short years of existence.

It is Baylor University Medical Center's mission to provide quality patient care, medical education, and research. Our continued growth and collaboration with one another in Texas, the United States, and countries around the world will benefit patients everywhere and strengthen the presence of medical research in Texas.

Lynn A. Gibson
Vice President
Baylor Research Institute
PO Box 710699
Dallas, TX 75226

Express your point of view in Texas Medicine

To submit a letter, send it to Texas Medicine, *TMA, 401 W 15th St, Austin 78701. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.*

Medicaid improvements important for Texas children

As facilitators of T-CATCH, Texas-Community Access to Child Health, sponsored by the Texas Pediatric Society and American Academy of Pediatrics, we wish to underscore the message of Dr H.N. Williston (*Texas Medicine*, July 1992, p 9) and also in the article, "Improvements in Medicaid program make it easier to participate," (July 1992, p 58). As efforts to reduce Medicaid hassles continue, we physicians need to participate more fully in taking care of children. As larger numbers of children are covered by Medicaid, physicians need to be there for them. Those physicians who are involved in the care of indigent children in the office or clinic will have a say as to how the rest of the children in the community receive care. They will be the ones to set the standards and goals for the care of all children.

Rebecca T. Kirkland, MD
Facilitator
Aaron L. Kreisler, MD
Co-Facilitator
Community Access to Child Health
Texas Children's Hospital
6621 Fannin St, MC 3-2305
Houston, TX 77030

The abortion issue: a "battle worth fighting"

I find it astounding that the Texas Medical Association is not willing to defend the rights of the unborn infants of this state. As *Texas Medicine* reported in July ("Delegates confront gun control, abortion," p 26), the resolution opposing abortion that was presented to the House of Delegates in May was defeated.

By its present policy, the TMA continues to sanction the procedure for any reason, even for contraceptive purposes and the convenience of the mother. It seems that we have tossed out all moral and ethical consideration in the name of privacy. On the one hand, the TMA objects to physician-assisted suicide by a consenting adult, objects to the use of illegal drugs by a consenting adult, objects to physician participation in a legal execution, and yet prefers not to interfere with the mass destruction of unborn infants for any reason!

This is totally inconsistent with the traditional values of medicine. What has happened to the traditional maxim to "do no harm"? What has happened to the Hippocratic Oath? Yes, we must assist those women who find themselves beset by an unplanned and undesired pregnancy, but it surely doesn't merit the sacrifice of an innocent human life! More than 30 million infants have been destroyed by physicians in this country since *Roe v Wade*. We have even exceeded Adolf Hitler in the extermination of an entire segment of society — those unborn infants who are the most helpless and defenseless of all.

How hypocritical it is for organized medicine to mount such a herculean effort to save the lives of premature infants and yet simultaneously to destroy healthy unborn infants. Have we all bought into the philosophy that it's acceptable since the infant happens to live within the body of another human being?

The TMA House of Delegates was not even willing to recommend that elective abortion be added to the list of procedures requiring informed consent. Should we not at the very least ensure that women are being informed of the risks and possible long-term consequences of the procedure?

I can only hope that many of you physicians who value the sanctity of human life will join with me in an effort to return medicine in Texas to its moral and ethical roots. This is truly the battle worth fighting.

Robert C. Matthews, MD
B and W Clinic
400 W Plummer
Eastland, TX 76448

Gun control and abortion: not our battle

Why on earth is the House of Delegates of the Texas Medical Association getting involved in the political debate about gun control and abortion? (See "Delegates confront gun control, abortion," *Texas Medicine*, July 1992, p 26.)

At a time when our very existence as private physicians is being threatened by outside forces from all directions, it is crucial for us to be unified. I can think of no two issues that have more potential to divide us than gun control and abortion.

I did not join the TMA to become a political activist. I support and defend my political and social positions actively on my own time. I want my medical association to address and, hopefully, to solve the problems for me and my patients with regard to the practice of quality medicine.

Please stop this unnecessary po-

larization of our members. Such divisive actions are potentially quite destructive to our organization and play precisely into the hands of those who would divide and conquer us.

R. Anders Rosendahl, MD
1200 Binz, Suite 1440
Houston, TX 77004

Heads up: legal case may affect valuing of medical practices

TRADITIONALLY, A PROFESSIONAL'S personal goodwill has constituted a major portion of his or her practice's value. This is especially true in the case of a subspecialist surgeon, for whom it may be essentially all of the practice's value.

Since it is impossible to quantitate personal goodwill in numerical terms, the Texas Supreme Court wisely ruled many years ago in a case styled *Nail v Nail* that it cannot be considered in the value of a professional's practice (1–4). Over the years, the trial lawyers have mounted steady pressure to change this case law. Obviously, if the trial lawyers are able to introduce into legal proceedings a large and highly debatable sum of money, such as personal goodwill, it would greatly open up their horizons for litigation. In short, personal goodwill is funny money that exists only in theory.

The Supreme Court has just agreed to hear argument in the case of *Guzman v Guzman* that will determine whether a professional's personal goodwill can still be excluded for the purposes of valuing a practice. Guzman is not a physician but the issue is whether a professional's personal goodwill can be valued and if so, whether the value is divisible at the time of divorce. Actually, the issues have much broader application than this, for if the court decides that value can be placed on a professional's personal goodwill, then this will affect the calculation of the net worth of every physician in Texas. This, in turn, will allow for much higher awards in civil liability cases, professional liability cases, and divorce cases involving professionals in Texas.

Obviously, this case could have a direct economic impact on every physician in Texas. Trial lawyers have already filed an amicus curiae brief with the Supreme Court supporting their self-interest in overturning Nail. In this election year, it is extremely important that physicians' viewpoint be clearly expressed to the Supreme Court candidates. I strongly encourage every physician to contact their TEXPAC and TMA representatives and president to make sure that our voices are heard and our TEXPAC dollars are working for us. TMA and TEXPAC can be reached at (800) 880-1300 or (512) 370-1300.

Brian B. Berger, MD
3901 Westlake Cove, #12
Austin, TX 78746

References

1. Nail v Nail, 486 SW2d 761 (Tex 1972).
2. Hirsch v Hirsch, 770 SW2d 924 (Tex App — El Paso 1989, no writ).
3. Rathmell v Morrison, 732 SW2d 6 (Tex App—Houston [14th Dist] 1987, no writ).
4. Austin v Austin, 619 SW2d 290 (Tex Civ App —Austin 1981, no writ).

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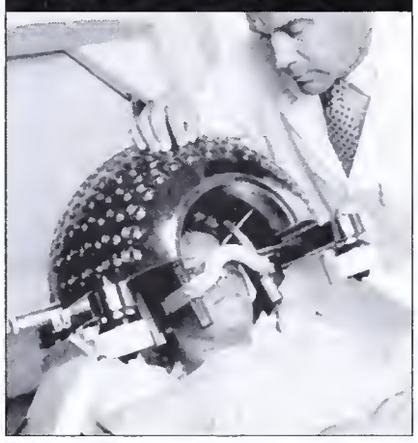

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Upfront

Members advocate updated TMA mission and priorities

BUILDING CONSENSUS ABOUT the aims of the Texas Medical Association is an exhausting — but essential — process that will keep the association strong and effective, say those behind TMA's annual Leadership Planning Conference held in Austin July 25–26, 1992. From this year's meeting came a proposal for a simplified mission statement, a series of strategies for carrying out the mission, and goals for 1993 and beyond.

Representatives of TMA boards, councils, committees, sections, and the Alliance voiced opinions and championed causes in a weekend of meetings that resulted in recommendations made to the TMA Board of Trustees.

Based on those suggestions, the board proposed "Improve the health of all Texans" as the association's mission statement, formerly called the key objective. The current key objective is "Improve the health of Texans through the professional and personal development of member physicians." The board also recommended key strategies and priority goals for 1993 and long-term.

From left, TMA President William G. Gamel, MD, Austin, and Alan C. Baum, MD, Houston, chairman of the TMA Board of Trustees, greet Howard Falkenberg, who served as facilitator at the TMA Leadership Planning Conference.

In November, the TMA House of Delegates will consider the board's recommendations.

The key strategies recommended by the board are:

- Achieve excellence in every association activity through advocacy for our patients and the profession of medicine.
- Strengthen the role of the physician and the association as the authoritative source of health-care information.
- Enhance the reputation of the association and its members through professional and personal development.
- Maintain a member-driven approach based on awareness and effective communication.
- Vigorously defend the physician-patient relationship.
- Maintain an active involvement with medical education at all levels.

TMA President William G. Gamel, MD, Austin, reminded physicians at the TMA Leadership Planning Conference that the "House of Medicine must remain united."

Proposed priority goals for 1993 are to assure the successful outcome of the legislature's sunset review of the Medical Practice Act, strengthen member communication and networks, address physicians' concerns regarding the regulation of medical practice, support equitable access to health care for all Texans, and promote preventive care. The priorities, if approved by the House, will serve as a basis for planning and budgeting for the coming year.

Proposed long-term association priority goals are to maintain strong emphasis on membership recruitment and retention, intensify member advocacy, ensure access to physician-directed care, enhance the practice environment, and promote wellness through preventive care and education.

Also during the Planning Conference weekend, The Durham Conference Room in the TMA building was dedicated in honor of contributions to the association from Patricia Durham and her husband, the late Mylie E. Durham Jr, MD. Dr Durham, a former TMA president and chairman of the Texas delegation to the AMA, died June 3, 1991.

House of Delegates poised for action

THE TEXAS MEDICAL Association's House of Delegates will meet November 20–21 at the Doubletree Hotel in Austin.

In addition to conducting its reg-

Suggestions sought for physician profile series

TEXAS MEDICINE plans a series of profiles of fascinating Texas physicians and medical students and would like your help in choosing the subjects of the series.

While professional achievements are one measure of a physician's worth, the series will not be limited to those who have achieved the most in this one area. Rather, physicians and medical students who are particularly fascinating people — perhaps because of their lifestyles, hobbies, histories, families, or accomplishments — will be considered for the series.

If you know someone (yourself?) who would make a good focus for an article, please let us know. Call or write Kathryn Trombatore, managing editor, *Texas Medicine*, 401 W 15th St, Austin, TX 78701, (800) 880-1300 or (512) 370-1380.

ular business, the legislative and policymaking body will adopt priorities for the coming year.

Immediately following the opening session on Friday afternoon, reference committees will meet to consider reports from the association's boards, councils, committees, and sections, and resolutions from county medical societies.

All members of TMA are welcome to attend and participate in hearings of the reference committees, which will report their findings and recommendations to the delegates Saturday morning, November 21.

October 12 is the deadline for submitting resolutions to the House of Delegates.

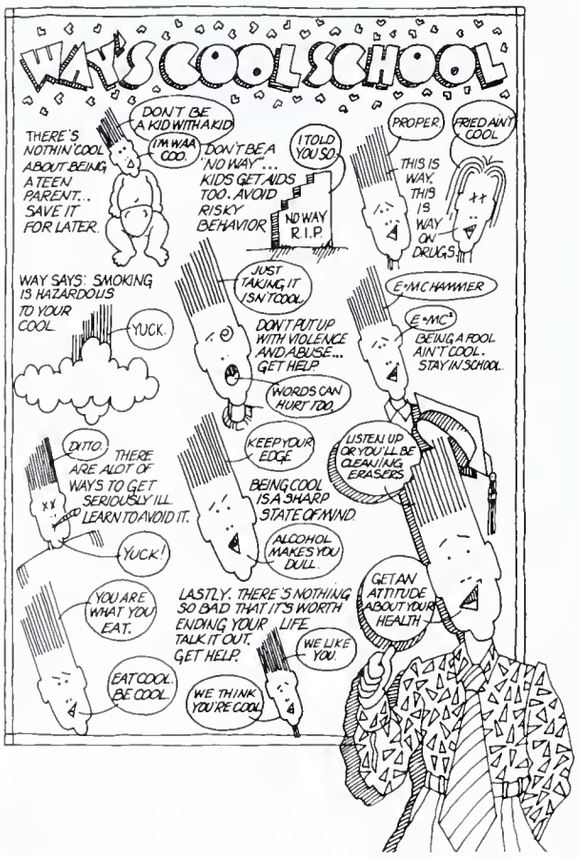
Additional details about the meeting are available from Sharon Walker, Texas Medical Association, 401 W 15th St, Austin, TX 78701, (800) 880-1300 or (512) 370-1325.

TMA Alliance spreads a "Way Cool" message

"WAY COOL," THE popular spokesman for the TMA Alliance's Healthier Youth 2000 project, is reaching half a million Texas students this fall on school book covers.

Sponsored by TMAA in cooperation with TMA, the project received a boost this year with contributions from the Texas Medical Association Insurance Trust, Blue Cross-Blue Shield, PCA Health Plans of Texas Inc, Texas Medical Liability Trust, The Prudential Insurance Company of America, Texas Pediatric Society, Texas Association of Obstetricians and Gynecologists, Texas Society of Internal Medicine, and the Texas Academy of Family Physicians.

Medical alliance chapters received quantities of the book covers based on their membership size and were asked to target junior high students. The book covers feature "Way's Cool School" on the back, with health messages presented in cartoon form.



New Way Cool materials this year include brightly colored posters featuring Way Cool and his new friends, Respect Yobodi and Carmen Sense, radio PSAs, brochures, and life-size cutouts of Way Cool himself, added to last year's popular hot-line cards with crisis numbers for kids.

For more information or a free single copy of the book cover, contact Kitty Kress at (800) 880-1300 or (512) 370-1328, or write TMAA at 401 W 15th St, Austin, TX 78701.

New member service cuts overnight shipping costs

THANKS TO TMA'S collective buying power, a new agreement with Airborne Express will reduce overnight express shipping costs for association members by up to 44%. An $8.75 rate (for 8 oz overnight letters) is available to all TMA members, and those averaging five shipments per day qualify for a lower rate.

Airborne Express provides free pick-up and next morning delivery of documents and small packages to most US cities and to 183 countries.

To participate in the TMA/Airborne Express program, members must sign up and receive an account number. Call (800) 289-2776 and tell the operator you are a TMA member. Your account number and starter kit will be sent within 1 week.

Sharpen your pencils, puzzle fans

COMBINING A TECHNICAL challenge and a little "light relief" amongst *Texas Medicine*'s more serious material, a medical crossword puzzle makes its first appearance in this issue. The puzzle is on p 88 and its solution is on p 26.

The puzzle is produced by Novel Puzzles Australia, which produced the first medical crossword 2 years ago and publishes puzzles in several medical journals in the Asia Pacific region and in North America.

The puzzle will appear at the back of *Texas Medicine* for 6 months and will be continued if readers' response is positive. To comment, contact Kathryn Trombatore, *Texas Medicine* managing editor, (800) 880-1300 or (512) 370-1380.

Call for Annual Session scientific exhibits

PHYSICIANS, RESIDENTS, interns, medical students, and allied health personnel are invited to show scientific exhibits at TMA's 1993 Annual Session in Houston, May 13–16. Displays need not be elaborate; poster exhibits are welcome. Contact Dale R. Werner, exhibits manager, at (800) 880-1300 or (512) 370-1455 for more information.

Empathy and compassion: tools to combat stresses of an illness

By Margaret D. Shifrin, RN, JD
Director, Office of Health Care Quality and Risk Management
The University of Texas System

ABOUT 2 YEARS AGO, IN MY capacity as a University of Texas attorney, I was investigating a medical liability claim concerning a patient at one of the university's health facilities. I spent a day at the hospital so I could meet with four of the patient's doctors and a head nurse. At the end of an interview, one of the physicians expressed frustration with the situation: "Margaret, you know these plaintiffs have no legitimate claim. The patient would have died no matter what we had done."

I responded that my investigation was leading me to agree with his conclusion.

The physician then asked, "Why do plaintiffs who obviously have no case go to the trouble of suing?"

I answered that illness or injury is very stressful and some people respond to the stress by suing, especially if they are angry.

"But Margaret, this wasn't a stressful case. I've been involved with many cases that I found much more difficult."

The doctor was correct. From his perspective the case was not stressful. I am sure he regularly sees patients who have suffered traumatic injuries involving multiple body systems that he finds far more challenging. When I worked as a floor nurse I realized some patients were more stressful to care for than others. Some were not stressful at all.

Health-care professionals cannot get "stressed out" about every patient because if they do they will not be able to perform their duties. But they need to be aware that to the patient and the patient's family, *any* illness or injury is a stressful experience. Stress can come from a host of factors: unanticipated problems, fatigue (physical and emotional), the unfamiliar clinical environment, overstimulation, uncertainty, confusion, and unmet expectations.

I was the wife of a brain tumor patient. About 6½ years ago my husband was diagnosed to have an astrocytoma. Michael's condition was probably not stressful to his physicians and other health-care professionals, but to Michael and his family, the situation was very stressful. In fact, the week of Michael's diagnosis was more stressful to me than any week I have spent before or since. The impact of the illness on all our lives was tremendous.

Stressors associated with catastrophic illness or injury

Since Michael's diagnosis, I have talked with other patients and their families and I have identified several factors that commonly cause stress during a catastrophic illness or injury. While most families are not faced with every one of these stressors, they usually must deal with at least some of them.

First, the diagnosis may be a surprise, especially if the patient had previously been asymptomatic. Second, the patient and his loved ones may be exhausted due to a lack of sleep. They may suffer from insomnia due to anxiety or to jet lag if they have traveled to get to the medical center. They may not be eating properly.

They are likely to be stressed because they are in unfamiliar sur-

roundings. To the health-care professional, the hospital is a workplace; to the patient, it is a frightening institution where he or she is subjected to pain and indignity.

The patient and the family also are probably overstimulated by the illness. Suddenly they are the center of much attention. They experience new emotions and numerous dramatic mood swings. I remember feeling as if I were on some sort of stimulant drug.

Soon after the diagnosis, the patient and family are overwhelmed with visits and calls from friends and distant relatives, some of whom have not been heard from in years. During this period, they are meeting many new people, including doctors, nurses, various types of therapists, and chaplains. In addition to learning a new vocabulary of medical terms, they are learning about new drugs, possible treatments, and side effects.

They may suddenly have money problems, particularly if the patient has no medical insurance or if he or she will no longer be able to work. If children are involved, there will be anxieties over the impact the illness will have on them.

In our culture, we have a myth that doctors know everything. Doctors are very intelligent and well educated, but they do not know everything and it is unfair for the public to expect that they do. Often physicians cannot be absolutely sure they are right when they make a diagnosis or prescribe treatment, so they must rely on their best judgment. You understand this, but your patients probably do not.

When a person gets sick, he or she wants you to know all the answers and it is stressful to learn that a cure may not be that easy. When two physicians have different opinions concerning the patient's condition or treatment regimen, it creates confusion and uncertainty for the patient and his or her family. This happens all the time.

For example, in our case, Michael's internist recommended that the astrocytoma be biopsied. One neurosurgeon recommended a needle biopsy; another neurosurgeon recommended a craniotomy. None of us knew anything about neurosurgery or astrocytomas, and it was confusing to get two such different opinions. Michael eventually made his decision based on the bedside manner of the physicians. We also got varying opinions concerning the grade of the tumor, Michael's prognosis, and the appropriate drug and radiation dosages. People naturally become frustrated with differing opinions and may wonder why the doctors do not agree or even whether the doctors are incompetent.

In an ideal world, people would have adequate coping skills and would not take out their frustrations on health-care professionals.

Common emotional responses to illness or injury

During a catastrophic illness, patients and family members are likely to be angry at themselves or each other. In popular television shows and novels, when someone becomes ill or is seriously injured, his or her loved ones pull together to offer each other strength and support. This does not always happen in real life. Initially people may unite to accomplish their common goal of defeating the illness, but it often does not take long for family members to become angry with each other. Relatives may blame each other for the situation, or they may engage in heated arguments about which medical treatment the patient should receive and which doctor and medical center should provide the treatment.

Friends and family sometimes regret their previous behavior toward the patient and may project their guilt onto someone else — like you. For example, instead of acknowledging they really feel bad because they neglected to spend time with the patient years before, they may blame you for not curing the patient even though you are not at fault. This is not rational, but it happens. In an ideal world, people would have adequate coping skills and would not take out their frustrations on health-care professionals. However, depending on how you interact with them, some may find it easier to project their anger onto you rather than deal with it rationally.

After Michael's diagnosis, I experienced an interesting phenomenon. You might expect a patient's family members to be distracted and unable to focus on details, but I found that my sensitivity to detail was heightened throughout the hospitalization period. I focused on all kinds of seemingly insignificant details, and I remember them to this day: I remember the clothes both Michael and I wore to the hospital the morning he was admitted; the shoes the internist was wearing when he met us at the emergency room; conversations I had with nurses and doctors during the hospitalization; times of

day conversations were held and phrases that were used. This may seem strange, but the fact that I remember all these details 6½ years after the event tells us something. If I am able to remember the shoes the internist was wearing at the time of admission, I would have had no problem remembering anything anyone had said or done that I found offensive or detrimental to my husband's health.

Sometimes a patient or family members will raise questions you may consider a waste of time or even outrageous.

Ways to minimize stress

Our hospital experience was as positive as it could have been under the circumstances because of the steps the health-care professionals took when interacting with us.

I was allowed to be present during Michael's examination in the emergency room. This made Michael calmer and it made me feel that I was participating. I remember the examining internist explaining everything to both of us. Unless the patient states that he or she wants to be examined in private, the significant other is hysterical, or the patient's condition is so critical that a family member would be in the way, I encourage allowing a family member or close friend to be present during at least some of the examinations. This will let that person know that you consider him or her to be a vital team member in fighting the illness. The family member may also be able to provide information to help in diagnosis and treatment decisions.

The day after Michael was admitted, the emergency room physician stopped by to tell us he was sorry about the diagnosis and to see how we were doing. This visit conveyed that the doctor saw us as more than some "case" he had handled; he really cared about us.

The neurosurgeon we consulted for a second opinion, and whom Michael ultimately selected to perform his biopsy, had an excellent bedside manner. When the surgeon met us in Michael's room, at least 10 family members were standing around Michael's bed. Before discussing anything, the doctor asked Michael if he would like to talk with all the people present, or if he would prefer to confer in private. This conveyed the doctor's respect for Michael's privacy. After Michael said he wanted everyone present, the doctor proceeded. He obviously was not nervous having a large audience. This surgeon, who at the time was only the consulting physician, spent about an hour with us, answering questions from both Michael and the family members. No one felt rushed. This doctor did not let economics interfere with his bedside manner and this made a tremendous impression on everyone.

Sometimes a patient or family members will raise questions you may consider a waste of time or even outrageous. Desperate for a cure, they want to know all possible options, including alternative treatments such as unconventional diets, massage therapies, or faith healing. It is best not to dismiss the proponents of such treatments as uneducated buffoons. Frequently, they are intelligent, well-educated people who may have significant influence over the patient's decisions. If you are skeptical of the value of the proposed alternative treatment, I suggest stating that you are unaware of scientific evidence that the treatment has worked, but that you see no harm (other than the expense) in the patient trying the therapy as long as the patient also complies with the prescribed treatment. If nothing else, the unconventional therapy may have a placebo effect. Of course, you should inquire about what the alternative treatment involves to be sure it really is harmless before authorizing the patient to pursue it.

On the first postoperative day, my sister-in-law and I were in the ICU discussing the impact of Michael's unexpected diagnosis. We were really just trying to digest the news, sort through all our emotions, and anticipate problems. An ICU nurse approached and we told her what we were discussing. She asked if she could join us for a few minutes. Later, another ICU nurse also sat down. During our conversation the nurses sat quietly and listened. Occasionally they nodded or made brief comments reflecting what we were saying (eg, "It's a difficult situation") but most of the time they said nothing.

It would have been tempting for the nurses to make comments like, "Oh, don't worry . . . everything will be okay," but that would have trivialized our legitimate anxieties and would have cost them their credibility. How could they possibly know everything would be okay? Another inappropriate remark would have been, "Last week I was talking to another astrocytoma patient's family about this, and I think you should do what they did." We

were not asking for advice and I do not think we would have been receptive to it at that time. A particularly insensitive remark would have been, "My aunt had a brain tumor, so I know just how you feel." Even if they had been through a situation identical to ours, they could not know how we felt because they could not get inside our heads. Those nurses resisted any temptation they may have had to say something in order to prove their expertise, because they recognized that we needed to ventilate. The therapeutic effect on us was tremendous.

You also may find it beneficial to just listen as patients and family members ventilate. However, sometimes you may be so busy that you cannot stay and listen. At such times I recommend saying something like, "You sound upset about your illness. This makes sense: it's a lot to deal with. I'm concerned about you. Right now I have to go and see another patient, but may we discuss this again tonight?" If the patient or family member seems distraught and in need of immediate attention, I suggest saying, "You sound very upset about the situation and I am concerned about you. I need to go now, but I am going to ask one of the hospital social workers [or nurses, chaplains, . . .] to see you. I will check back with you this evening."

Mistakes in interacting with patients and their families

We were treated very well by Michael's doctors and the hospital staff, but one physician did make several mistakes interacting with us that made us angry.

Before the doctor discussed the procedure he wanted to perform, he invited us all out of Michael's room to look at the CT scan films. Michael was confined to the room because his IV was on a pole attached to the bed. The doctor spent about 20 minutes talking about what he wanted to do. Finally Michael's sister expressed concern because Michael was being left out of this very important conversation. The doctor ignored her and continued to talk. Based on this mistake we perceived the doctor to be arrogant, insensitive, and probably uncomfortable relating to patients. I encourage including the patient in all conversations concerning his or her care unless you honestly believe the information would be detrimental to the patient's health.

This doctor also offended us by referring to the nurses as "the girls on the floor," telling us, for example, "After I finish this procedure, the girls on the floor will follow my orders and take good care of him." First, not all nurses are women. Second, this kind of term expresses lack of respect for skilled professionals who are taking care of patients. It makes patients wonder if the doctor thinks the nurses are competent. It also makes nurses wonder if the doctor takes them seriously. Finally, it is offensive to many women to be referred to as "the girls" even if they refer to themselves that way.

Conclusion

I have discussed experiences I had as a patient's wife. Now I will mention that in addition to being a nurse and an attorney, I am also a doctor's daughter.

I understand that physicians are under an incredible amount of job-related pressure. You work long, hard hours and are frequently required to provide care in the middle of the night. You must devote much time to stay current with your specialty. You are accountable not only to patients and their families; you must also answer to hospital administrators, insurance companies, and government auditors, as well as the other doctors on staff.

I do not suggest that you increase your burdens by taking on stresses of your patients, but I do recommend that when interacting with patients and their family members, you combat the stresses of illness with empathy and compassion. Your patients and their families will appreciate your sensitivity. In addition, your efforts could prevent patients and their family members from taking out their frustrations on health-care professionals if medical complications arise. ★

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People

NEWSMAKERS

Brownwood family practitioners **Gwendolyn Allen, MD,** and **Curtis Blake, MD,** were awarded certificates from the Texas Department of Health for their dedication to infant health through the promotion of breastfeeding.

The Texas Medical Foundation announced the election of Fort Worth internist **John F. Brenner, DO,** and Georgetown general practitioner **William R. Jones, DO,** to 3-year terms on its board of trustees. Dr Brenner was appointed to the utilization and quality review oversight committee and Dr Jones will serve on the finance and personnel committee.

The Gulf Coast Medical Center board of trustees dedicated the new Gulf Coast Regional Cancer Center to retired Wharton general surgeon **Robert B. Caraway, Jr, MD.** Active in cancer prevention, diagnosis, and treatment, Dr Caraway was responsible for the accredited cancer program at the medical center and the establishment of its tumor registry, one of the first in Texas.

San Antonio psychiatrist **Harry A. Croft, MD,** received an award from the Mental Health Association for his public education efforts about mental health issues. Dr Croft's television segments are syndicated throughout Texas and he is featured weekly on a local radio talk show.

John Horner, left, chief executive officer of the National Mental Health Association, presents a special award to Harry A. Croft, MD.

Carole Gordon, MD, Waco, was recently elected executive board secretary of Women in Urology, a national organization of female urologists.

The *Chez Eddy Living Heart Cookbook*, by **Antonio M. Gotto, Jr, MD,** received the James Beard Foundation Award as the best "healthier living" cookbook of 1991. The book features recipes from Chez Eddy, the heart-healthy gourmet restaurant established by Houston's Methodist Hospital. Dr Gotto is chief of the internal medicine service at The Methodist Hospital and a past president of the American Heart Association.

Ronald A. Hellstern, MD, Dallas, received the James D. Mills Outstanding Contribution to Emergency Medicine Award, the highest honor given by the American College of Emergency Physicians. Dr Hellstern is a member of the Texas Board of Health's trauma advisory committee, which formulates and administers the Texas trauma system.

Ronald A. Hellstern, MD

Isabel V. Hoverman, MD

Isabel V. Hoverman, MD, an Austin internist and former president of the Texas Society of Internal Medicine, has accepted an invitation to serve a 3-year term on the practicing physicians advisory council of the Health Care Financing Administration.

Bernard Levin, MD, has been appointed interim vice president for cancer prevention, a new position created to help enhance the cancer prevention mission of The University of Texas M.D. Anderson Cancer Center.

Warren Moore, MD, chief of service for nuclear medicine at St Luke's Epis-

Please let *Texas Medicine* know about your honors and achievements.

Criteria for inclusion in the Newsmakers section are: TMA member; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, Texas Medicine, *401 W 15th St, Austin, TX 78701.*

copal Hospital in Houston, was elected president of the southwestern chapter of the Society of Nuclear Medicine and a voting member of the board of trustees.

Neurologist **Jeffrey Noebels, MD, PhD,** from Baylor College of Medicine, has been elected to the board of directors of the Epilepsy Foundation of America.

Charles S. Petty, MD, was selected distinguished pathology educator of 1992 by the American Society of Clinical Pathologists. Dr Petty, a professor of forensic science and pathology, is associate medical director of the transplant services center at The University of Texas Southwestern Medical Center at Dallas.

Donald A. Podoloff, MD, of The University of Texas M.D. Anderson Cancer Center, is president-elect of the southwestern chapter of the Society of Nuclear Medicine. He will assume the presidency of the organization in 1993. Dr Podoloff is deputy chairman of the department of nuclear medicine and associate professor of radiology and nuclear medicine.

Robert E. Rakel, MD, was honored with the F. Marian Bishop Leadership Award by the Society of Teachers of Family Medicine. Dr Rakel was recognized as a successful family medicine role model for his leadership as a residency director, department chair, and an associate dean at Baylor College of Medicine.

Cameron area citizens celebrated "Dr Sid Richardson Day" with a public reception hosted by the Central Texas Hospital Auxiliary. Family practitioner **Sidney H. Richardson, MD,** was recognized for 35 years of medical and civic service. In speaking with a local newspaper reporter, Dr Richardson assured the community that he has no thoughts of retiring.

Lubbock radiation oncologist **Sidney C. Roberts, MD,** has accepted a 3-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Southwest Cancer Center/University Medical Center. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

Robert Saxton, MD, is the president-elect of the Texas Association of Neurological Surgeons. Dr Saxton also serves as southwest quadrant chairman of the joint council of state neurosurgical societies of the American Association of Neurological Surgeons.

Joseph Sellin, MD, director of the division of gastroenterology at The University of Texas Medical School at Houston, received the Physician of the Year Award from the Crohn's and Colitis Foundation. He also has accepted the position of regional medical advisor for the organization.

The American Occupational Therapy Association presented the Community Connection Award and the Health Advocate Award to **William Spencer, MD.** As the founder and first president of the Texas Institute for Rehabilitation and Research, Dr Spencer was honored for his contributions to the health and advancement of the rights of disabled individuals. He also received the "Physician of the Year" award from the US Commission on the Employment of Disabled Persons and was instrumental in formulating the Americans with Disabilities Act.

Patricia J. Sulak, MD, assistant professor of obstetrics/gynecology at Texas A&M University College of Medicine, was appointed an associate board examiner by the American Board of Obstetrics and Gynecology. Dr Sulak will conduct oral examinations for physicians applying for board certification.

Dallas internist **David Winter, MD,** received the highest award from the National Association of Physician Broadcasters for excellence in medical broadcasting. The Jules Bergman Award was presented to Dr Winter for his dedication to health education through both broadcast and print media.

OBITUARIES

Joe O. Arrington, Jr, MD, 64; Lubbock; Vanderbilt University, 1952; died July 20, 1992.

William Walton Bondurant, Jr, MD, 86; San Antonio; The University of Texas Medical Branch at Galveston, 1929; died June 6, 1992.

C.G. Brown, MD, 64; Tyler; The University of Texas Southwestern Medical School, 1954; died July 12, 1992.

Victor Leal, MD, 53; Brownsville; Universidad de Nuevo Leon, 1968; died August 4, 1992.

Robert H. Millwee, Jr, MD, 77; Dallas; Baylor College of Medicine at Dallas, 1940; died July 6, 1992.

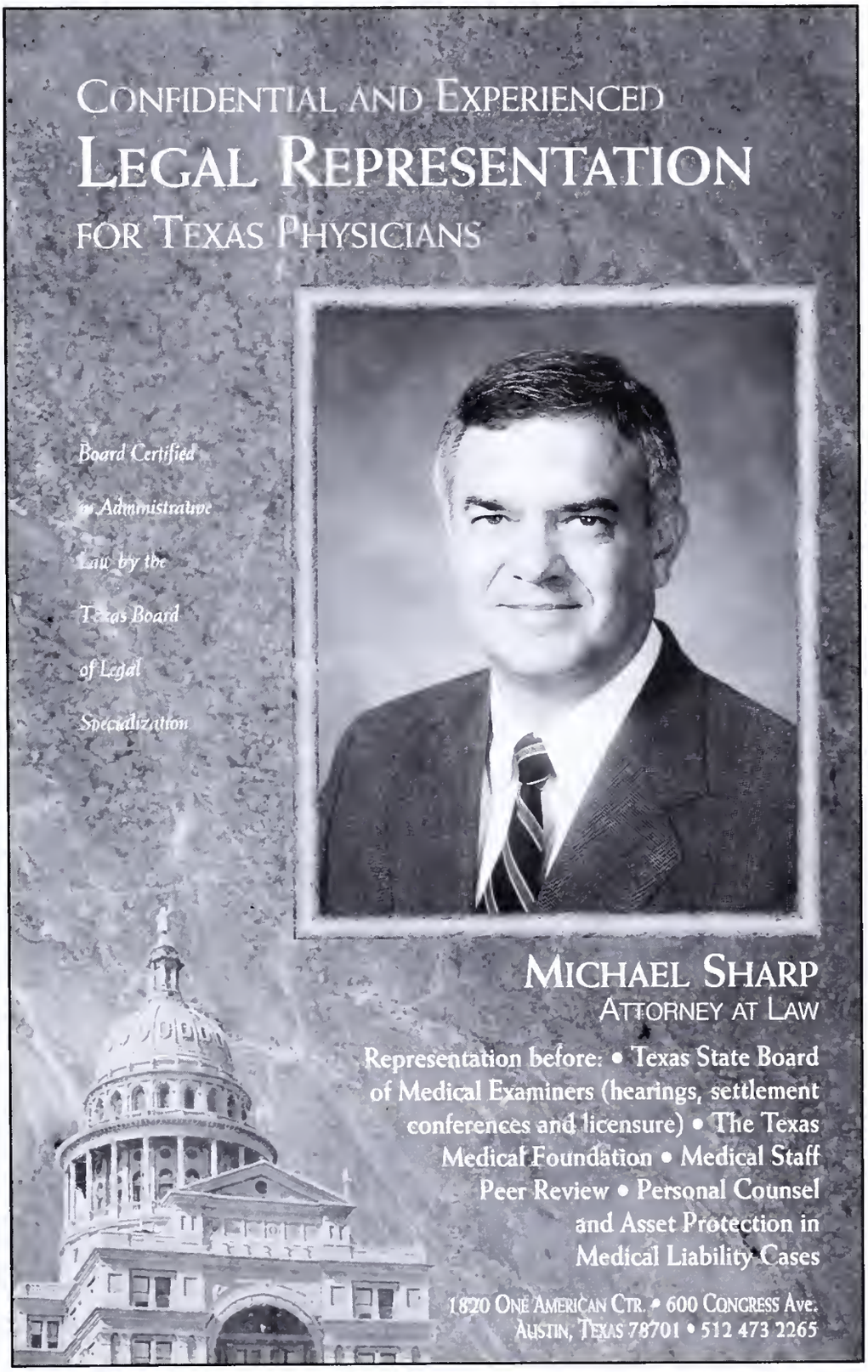
Marvin Bradfield Oxford, MD, 73; San Antonio; The University of Texas Medical Branch at Galveston, 1942; died April 5, 1992.

Whitman Rowland, MD, 56; Lufkin; Tulane University, 1961; died April 17, 1992.

Harry A. Tubbs, MD, 77; Post; Medical College of Virginia, 1939; died July 25, 1992.

John Allen Welty, MD, 73; Harlingen; The University of Texas Medical Branch at Galveston, 1942; died July 21, 1992.

Corinne Westphal, MD, 84; Yorktown; Washington University School of Medicine, 1934; died July 14, 1992.



The Hospital Medical Staff Section Twentieth Assembly Meeting December 3 - 7, 1992 Opryland Hotel Nashville, Tennessee

Highlights of the Interim Meeting will include an educational program on:

Part I: A Futurist's Picture of Health Care 2000

A highly recognized consultant in health care issues will provide his perspective of the factors that will influence the reform of the health care system in the decades to come. Having painted a picture of Health Care 2000, the futurist will respond to questions of a reactor panel which will focus on:

- the role of organized medicine in framing the future health care delivery system,
- the role physicians will play in shaping the future and assuring adequate access to high quality health care services, and
- the impact that anticipated changes in the health care delivery system will have on the hospital medical staff's relationship with the community outside the hospital setting, including the payers.

Part II: Physician / Hospital Organizational Models for the Future

The relation of the hospital with members of its medical staff will be substantially impacted by the forces that are shaping national health care policy and the health care delivery system of the future. The HMSS Representatives will learn:

- what some states are doing to serve as "laboratories" for alternative health care delivery systems,
- what the AMA is doing to study and advise physicians on the appropriateness of various physician / hospital organizations, and
- what one consultant anticipates will ultimately be the prognosis for organizational relationships between health care providers.

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Science and Education

Congress passes Animal Enterprise Protection Act

CONGRESS HAS APPROVED the Animal Enterprise Protection Act of 1992, a bill sponsored by US Rep Charles Stenholm (D-Tex), designed to protect biomedical research facilities from animal rights extremists and others who may seek to disrupt or destroy experiments using laboratory animals.

President Bush signed the bill on August 26.

The act, which had 264 cosponsors in the House and 32 cosponsors in the Senate, provides penalties for those animal rights terrorists who destroy research or threaten researchers, while preserving the rights of reasonable animals rights groups to protest and make their opinions known.

The bill renders criminal penalties for "animal enterprise terrorism" defined as stealing, damaging, or causing the loss of any property (including animals or records) used by an animal enterprise. The act broadly defines an animal enterprise as a commercial or academic enterprise that uses animals for scientific research or tests, food or fiber production, or agricultural research.

Both the National Association for Biomedical Research (NABR) and the Texas Society for Biomedical Research (TSBR) strongly supported the bill during the last 3 years.

"Once again, Texans have taken the lead on a health issue vital to all Americans," said John Howe III, MD, PhD, president of TSBR. "In particular, Congressman Stenholm deserves kudos for his personal advocacy on this important issue. Thanks to him and his leadership, our scientific community in Texas can rest easier in going about its business of developing new therapies for today's illnesses."

Dr Howe credits a grassroots network of letters, phone calls, and congressional visits by physicians and researchers with pushing the bill through Congress.

"TSBR played an important education role in getting this bill passed," he said. "But the entire membership of the TMA should feel very good about this vote. The TMA, from students to practitioners, was very vocal on this issue, arguing forcefully that it is important to patient care, both today and tomorrow."

> "ONCE AGAIN, TEXANS HAVE TAKEN THE LEAD ON A HEALTH ISSUE VITAL TO ALL AMERICANS."

TMA's House of Delegates voted in November 1989 to support the humane use of animals for education and research in Texas educational institutions and research facilities.

The bill's sponsor in the House said it was needed to help stop the wave of violent acts perpetrated against research facilities around the country.

"This bill is intended to penalize terrorist activity — violent activity — directed against biomedical researchers, farmers and ranchers, meat packers and processors, livestock auctions, and others who handle animals," Representative Stenholm said. "Such actions not only threaten existing food production and research, and impede advances, they have created a growing atmosphere of fear among farmers and researchers."

One congressman noted that the bill, while designed to protect animal research, does allow legitimate protest by those concerned with the welfare of animals.

"We strike with this legislation a balance between recognizing that animal rights groups have the right to picket, the right to write and demonstrate, and bring their projects to the fore," said Rep George Gekas (R-Pa). "But in the meantime, we must protect against the violence that some extremists and animal rights groups have been evidencing across the landscape for too long."

Among the cosponsors of the bill in the Senate were both Democratic Sen Lloyd Bentsen and Republican Sen Phil Gramm, both of Texas. In addition to Representative Stenholm, Reps John Bryant and Kika de la Garza (D-Tex) were credited with key roles in ushering the bill through the House.

Because it is federal legislation, offenses under the bill must be committed by individuals who have crossed an interstate or international boundary. It provides three levels of penalties. During an attack on an animal enterprise, anyone causing damages in excess of $10,000 may be sentenced to 1 year in jail; if someone is injured, the perpetrator could be sentenced to a 10-year jail term; and if someone is killed, punishment can be as much as a life sentence.

According to Dr Howe, the new federal law closely mirrors a measure passed in the 1991 Texas Legislature.

The new federal law also grants restitution in most cases and authorizes a joint study by the Departments of Justice and Agriculture on the extent and effects of domestic

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

New prostate disease center combines research, patient care

The University of Texas Southwestern Medical Center, Dallas — A new Prostate Disease Center will combine research and clinical medicine to bring advances in prostate disease research more rapidly to the patient's bedside. The center, one of only a handful of its type in the country, will draw specialists from UT Southwestern's departments of urology, endocrinology, molecular genetics, and pathology, and the Simmons Comprehensive Cancer Center. John D. McConnell, MD, director of the center, said shared facilities are designed to encourage daily interaction between caregivers and basic scientists. UT Southwestern is involved in several research projects involving prostate disease.

Nonsurgical procedure developed to treat brain aneurysms

Baylor College of Medicine, Houston — A new procedure to treat brain aneurysms from the inside out is being used by physicians to avoid traditional surgical techniques. The new procedure, platinum wire electrothrombosis, involves a catheter directed into an artery leading into the brain. The catheter is used to insert a platinum wire, which coils into a ball in the aneurysm. Then a mild electrical current is sent to the catheter, producing a clot and severing the ball of platinum, preventing blood from entering the area. Not only does the procedure avoid surgery, but it is considerably less expensive. The treatment is still experimental, but Baylor physicians say early results are encouraging.

Results released from NASA's Life Sciences Mission

Space Center, Houston — Scientists report dramatic changes to some of the body's critical systems during space travel, which may affect long stays in space. The findings are in the results of the Spacelab Life Sciences (SLS-1) mission flown aboard the Space Shuttle Columbia in June 1991. In late July 1992, the space agency reported key findings in the areas of cardiovascular, musculoskeletal, and neurovestibular physiology. Among the findings were those reported by C. Gunnar Blomqvist, MD, a cardiologist at The University of Texas Southwestern Medical Center in Dallas, who studies the effect of space travel on the working conditions of the heart and lungs. His studies, using a catheter inserted into the arm and later moved into the aorta, showed that astronauts experienced a much more rapid fall in central blood pressure than was predicted. Other studies examined the effects of space flight on the body's blood pressure regulating reflexes, the inner ear's mechanism for detecting gravity, and on the body's muscle and bone mass. The next Spacelab Life Sciences mission is scheduled for late summer or fall of 1993.

Experimental bladder cancer drug shows promise in trials

The University of Texas Health Science Center, San Antonio — An experimental oral drug, bropirimine, has rendered several bladder cancer patients disease-free in a multicenter human trial coordinated from San Antonio. The study's initial findings, published in the *Journal of Urology*, indicated that in the first study, 5 of 11 people with bladder cancer were cured, according to Michael F. Sarosdy, MD, associate professor and chief of urology. "Carcinoma in situ is an aggressive cancer, and the standard treatment used to be to take out the bladder," he said. In the study, researchers increased the dosage of bropirimine with each new patient and watched for side effects. Bropirimine works by stimulating the body to produce interferon. Other than its results, its major advantage is that it may be given orally, rather than administered through a catheter.

Information for this column comes from a variety of sources, including academic institutions, state and federal agencies, and private institutions. We welcome submission of items of interest. Send them to Texas Medicine, *Science and Education Editor, 401 W 15th St, Austin, TX 78701.*

and international terrorism on research, testing, and commercial uses of animals.

Physicians seek moratorium on cell-transplant research

A GROUP OF RESEARCH physicians and scientists, led by Henry F. Epstein, MD, of Baylor College of Medicine in Houston, have called for a moratorium on human trials of an experimental cell-transplant procedure designed to counter muscular dystrophy.

In a letter published with an article in the August 7 edition of the journal *Science*, a group of 25 scientists active in the field of muscle development and disease stated their concerns regarding recent studies of human myoblast implantation in male children with Duchenne's muscular dystrophy, often referred to as "myoblast therapy."

According to the letter, present studies indicate "only limited survival of the implanted myoblasts, little or no expression of dystrophin by these myoblasts, and no significant improvement in the clinical status of these children."

The letter also calls for a halt to human testing until further, more conclusive laboratory trials on animals can be completed.

Science quoted Dr Epstein as saying that the issue of informed consent is also a concern of scientists.

"The children themselves don't have informed consent," Dr Epstein said. "They rely on the parents. The parents, in this case, may not have informed consent either because of the emotional issues of having a child with Duchenne's.

"We think it is a time for stopping and reevaluating," he said. The researchers called for more study to be done on the topic and for human trials, when appropriate, to be done on adults with Becker's dystrophy, a related but less severe form of the disease.

The privately funded Muscular Dystrophy Association (MDA) is currently funding the myoblast therapy research, and an MDA spokesman was quoted as saying that for now, the research will continue.

Actors to help medical students improve skills

LIGHTS, CAMERA, DIAGNOSE! Aspiring actors and actresses heading for Hollywood just might pass through one of three Houston-area medical schools on their way to fame and fortune.

A $200,000 grant from the Josiah Macy Jr Foundation of New York to the Gulf Coast Regional Consortium in Houston will fund a pilot program using standardized patients — actors trained to simulate symptoms — for second-year medical students to interview and evaluate. The consortium consists of The University of Texas Medical School at Houston, The University of Texas Medical Branch at Galveston, and Baylor College of Medicine.

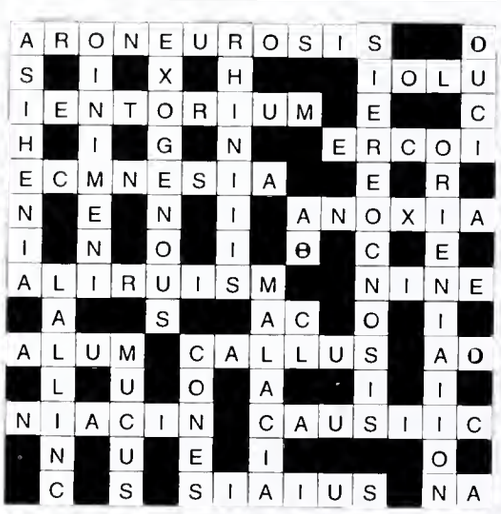
In the program, actors and actresses trained to dramatize the symptoms of a specified disease are interviewed by students, who evaluate and diagnose based on their observations. The interview is videotaped so students and their professors can later evaluate the session.

"The use of standardized patients in medical education is an important means of training doctors, enhancing their skills, and evaluating their performances," said George T. Bryan, MD, UTMB vice president of academic affairs and dean of the School of Medicine. He added that while each school will have its own testing site, all three will be linked to a computer database that will list standardized patients and medical histories.

"The computer network planned by this consortium could become a model for a national network among medical schools," Dr Bryan said.

The Macy Foundation, established in 1930, supports the education of health professionals, especially physicians. The Gulf Coast Regional Consortium was formed as a system for the three medical schools to provide standardized patients and other pooled resources for preclinical evaluation of students.

So don't be surprised some day when Hollywood's newest leading lady or man, in accepting an Academy Award, credits that chance to play an acute appendicitis as the "big break" in the business. ★



Crossword puzzle on p 88.

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Defending Defensible Doctors

Law

The physician's guide to medical waste regulations — part IV

Lynne M. Sehulster, PhD, M(ASCP)
Infectious Diseases Program
Epidemiology Division
Texas Department of Health

Leonard E. Mohrmann, PhD, CPC
Chief, Special Waste Evaluation Team
Municipal Solid Waste Division
Texas Water Commission

Patricia Garland, CPC
Special Waste Evaluation Team
Municipal Solid Waste Division
Texas Water Commission

C.J. Francisco III, JD
TMA Assistant General Counsel

THE ONLY CONSTANT IN THE world of regulations is change, and several significant changes have occurred in the medical waste rules and in state agencies.

With assistance from the Texas Department of Health and Texas Water Commission, *Texas Medicine* has previously published a series of articles on waste regulation in the state. Previous articles appeared in August 1991 (1), November 1991 (2), and December 1991 (3). Since then, however, some regulations have changed.

Current medical waste regulations are available from the Special Waste Evaluation Team, Municipal Solid Waste Division, Texas Water Commission, PO Box 13087, Austin, TX 78711-3087.

Legislation and medical waste

Prior to 1992, the state agency responsible for regulating medical waste treatment and disposal was the Texas Department of Health (TDH).

As of March 1, 1992, however, this authority was split between TDH and the Texas Water Commission (TWC) when the Bureau of Solid Waste Management was transferred to the TWC as a result of Senate Bill 2 (SB 2). Presently, the Texas Board of Health and TDH continue their authority to define the categories of waste subject to regulation and to establish standards for waste treatment prior to disposal. These rules are the Texas Board of Health Rules for Definition, Treatment and Disposition of Special Waste from Health-Care Related Facilities (Title 25, Texas Administrative Code, Chapter 1 [25 TAC 1], §1.131–1.137).

The authority to regulate medical waste removal and disposal remains with the Municipal Solid Waste Division, now within the TWC, according to Solid Waste Management Rules for Medical Waste Management, Disposal, Transportation, Collection, and Storage. These rules have been recodified (4), along with other solid waste management rules, as of March 3, 1992, from Title 25, Texas Administrative Code, Chapter 325 (25 TAC 325) to Title 31, Texas Administrative Code, Chapter 330 (31 TAC 330). The rules pertaining to Medical Waste Management are found in Subchapter Y, §330.1001–330.1009.

IN NOVEMBER 1991, THE BOARD OF HEALTH APPROVED THE LISTING OF TWO NEW TREATMENT TECHNOLOGIES . . .

Recent rules changes

Changes of greatest interest to the practitioner are found in the TDH Board of Health rules (25 TAC 1, §1.131–1.137).

In November 1991, the board of health approved the listing of two new treatment technologies and designated the minimum standards of operation as well as the categories of "special waste from health-care related facilities" (SWHCRF) that can be treated by these methods (5). These two processes are known as "moist heat disinfection" and "chlorine disinfection/maceration." A brief description of each is listed in the "Definitions" section of the rules (6):

- *Moist heat disinfection* — the subjection of:
  - (A) internally shredded waste to moist heat, assisted by microwave radiation, to a temperature of at least 95°C under atmospheric pressure for at least 30 minutes causing adequate disinfection as verified by routine performance monitoring using *Bacillus subtilis* test indicators; or
  - (B) unshredded waste in sealed containers to moist heat, assisted by low-frequency radio waves, to a temperature of at least 90°C under atmospheric pressure for at least 2 hours, followed by shredding of the waste to the extent that the identity of the waste is unrecognizable.
- *Chlorine disinfection/maceration* — the process of shredding waste in the presence of a chlorine disinfectant solution under negative pressure. The shredded waste must be unrecognizable as to the source. The chlorine disinfectant must have a free available chlorine concentration of 1,100 ppm when ap-

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

LEGAL NOTEBOOK

The following amicus curiae briefs were filed recently by the Texas Medical Association's Office of the General Counsel. "Friend of the court" briefs are filed in state or federal court when the outcome of a proceeding will have a substantial impact on Texas physicians and their patients. Amicus briefs are normally filed at the appellate level after the facts have been determined and the law applied at the trial level. The facts should present a genuine opportunity to support or defend the issue based on the importance to medicine.

- *Bernard Bradley, MD, v Rogers*

A Houston physician treated two patients who were in serious condition 2 days after undergoing liposuction surgery at another physician's clinic. As a result, the physician was one of several physicians sued, and an adverse jury determination for approximately $20 million (including interest) resulted. The trial court determined that the physician must post a $20 million bond in order to avoid having his assets satisfy the judgment during appeal. The Texas Medical Association filed an amicus brief on behalf of the physician challenging the bond. TMA's brief argued that both constitutional and legislative history of rules of civil procedure permit a reduction of the bond to an amount covered by insurance. Without such a ruling, the physician would have to declare bankruptcy in order to pursue his appeal. (At press time, the appellate court lowered the bond requirement to $1.1 million — the amount of liability insurance plus $100,000.)

- *Gibson v Methodist Hospital*

This case involves a patient at Methodist Hospital who allegedly contracted AIDS during a blood transfusion at the hospital during early 1983. Methodist Hospital was originally granted summary judgment in its favor by the trial court. The judgment was upheld on appeal by the appellate court. However, the Texas Supreme Court reversed and remanded the case. TMA filed a brief in support of Methodist Hospital's motion for a rehearing, arguing that it was against sound public policy to allow an unqualified expert witness, or any expert witness, to establish a standard of care and then to apply that standard of care retroactively.

plied to the waste. The disinfectant solution must be drained from the waste prior to disposal.

It is expected that use of these treatment processes will be limited to hospitals, other large quantity waste generators, and commercial processing facilities because these technologies are expensive and large-scale operations.

A change in the definition and standards for chemical disinfection may be more relevant to the individual practitioner who elects to treat SWHCRF prior to its removal from the premises. The new minimum standards for chemical disinfection are as follows:

- *Chemical disinfection* — the use of a chemical agent to reduce significantly microbial activity. The chemical agent used shall be registered with the United States Environmental Protection Agency as a disinfectant and shall be used in accordance with the manufacturer's instructions; or the waste shall be immersed for not less than 3 minutes in:
  (A) a freshly prepared solution of household bleach diluted 1:10 with water; or
  (B) a solution of 70% by volume 2-propanol (isopropyl alcohol).

  Waste that has been immersed in a liquid disinfectant must be thoroughly drained before disposal.

Processes for treatment under review

At the state level, some new processes for waste treatment are under review.

A rule change to allow emergency medical service (EMS) vehicles to unload wastes related to patient transport at the facility receiving the patient is also under consideration.

At the federal level, legislation has been introduced to extend the Medical Waste Tracking Act pilot program to all 50 states.

Recent revisions to the Texas rules in 31 TAC 330, Subchapter Y affect transporters but will not affect directly the people who generate waste, especially the small quantity generator.

The rules governing SWHCRF disposal in municipal landfills (Type I landfills) have changed only in the fact that as of March 31, 1992, landfills can no longer accept untreated SWHCRF. For the 18-month period prior to this date, approval to accept untreated SWHCRF was granted by TDH only for waste from generators located more than 75 miles from a commercial, permitted, operational medical waste treatment facility (7). All SWHCRF destined for landfill disposal now must be treated.

An important trend regarding landfill disposal of chemically-disinfected SWHCRF is mentioned in the definitions of the two new processes as well as that of chemical disinfection: namely, the draining or removal of liquid chemicals used to treat the waste prior to disposal. In the very near future, landfills will not be able to accept liquids for disposal, and so it becomes necessary to remove liquid germicides from the SWHCRF after treatment (8).

Definitions under TDH and OSHA

On the surface it appears that the two perspectives are in conflict, with OSHA's definition of "regulated waste" being more comprehensive in scope.

One must remember, however, that the TDH definition of SWHCRF is based on the Centers for Disease Control (CDC) guidelines on infectious wastes and the *environmental* impact of these wastes, while OSHA is concerned with waste management as it relates to employees' *occupational exposure* (9).

While the TDH definition and categories of SWHCRF have not changed, the definition of wastes subject to OSHA regulation has been revised in the final federal standard (10). Regulated waste is defined as liquid or semiliquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semiliquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood; or other potentially infectious materials.

While there is some agreement about certain categories of waste (ie, contaminated sharps, pathological wastes, and microbiological wastes), the greatest discrepancy between the federal and state regulations focuses on non-sharp, disposable items contaminated with blood and other potentially infectious materials. TDH does not include these in the definition of SWHCRF. Rather, these items fall within the definition of "other regulated medical waste," thereby acknowledging that the handling or management of these items may be regulated within a facility as per the OSHA bloodborne pathogen standard (11).

OSHA disposal requirements

Regulated waste within the facility must be placed in containers constructed to contain all contents entirely and to prevent leakage of fluids at any time.

The containers must be closable and must be closed when removed for disposal to prevent spillage and leakage. The containers must also be clearly labeled with warning labels, such as with the "BIOHAZARD" notation and symbol. These labels shall be fluorescent orange or orange-red, or predominantly so, with the letters and symbol in a contrasting color. Alternatively, the containers may be color-coded red or red bags used for hazard communication.

Once the container and its contents have been decontaminated, the hazard communication labels or colors are no longer required (12). Containers for contaminated sharps must meet the criteria listed above, plus they must be puncture-resistant and leak-proof on sides and bottom. The containers also must be readily available for use and kept upright, replaced routinely, and must not be overfilled (13).

THE GREATEST DISCREPANCY BETWEEN THE FEDERAL AND STATE REGULATIONS FOCUSES ON NON-SHARP, DISPOSABLE ITEMS CONTAMINATED WITH BLOOD AND OTHER POTENTIALLY INFECTIOUS MATERIALS.

Disposal of non-sharp, disposable items

Non-sharp, disposable items contaminated with blood and other potentially infectious materials do not have to be treated unless commingled with wastes identified as TDH SWHCRF categories.

Containers with these non-sharp, disposable items (other regulated medical waste) may be discarded with routine municipal solid waste provided that a label has been affixed to the container stating that the waste contained therein is not a SWHCRF (14). The "relabeling" or "repackaging" of these wastes in preparation for disposal through the routine waste stream helps to cut down the volume of waste leaving the facility for treatment and disposal, and reduces waste disposal costs as well. This approach to waste management is permitted under the OSHA bloodborne pathogen standard as complying with state and local waste disposal regulations (15).

Patients' disposal of needles and syringes

Currently, the wastes from single- or multifamily dwellings, and hotels, motels, or other accommodations providing lodging and services to the public are exempted from the provisions of the Texas medical waste rules (16).

Both TDH and TWC, however, encourage practitioners to educate patients about responsible disposal of needles and syringes (sharps). The TDH staff has received numerous calls from concerned parents whose children have handled needles and syringes discarded in parks, public restrooms, along streets, and in dumpsters. Discarding used sharps into a hard-plastic or metal container with a screw-on or otherwise tightly secured lid is recommended by the Environmental Protection Agency (EPA).

The EPA has published a brochure, *Disposal Tips for Home Health Care* (EPA/530-SW-90-O14B), on home disposal of needles and syringes. The brochure is available by calling (800) 424-9346 or contacting RCRA Docket (OS-305), Environmental Protection Agency, 401 M St, SW, Washington, DC 20460.

References

1. See "The Physician's Guide to Medical Waste Regulations," *Tex Med.* August 1991:52–55.
2. See "The Physician's Guide to Medical Waste Regulations, Part II," *Tex Med.* November 1991:21–23.
3. See "The Physician's Guide to Medical Waste Regulations, Part III," *Tex Med.* December 1991:28–31.
4. *Tex Register* 17: 1649–1651, March 3, 1992.
5. Tex Dept of Health, 25 Tex Admin Code, §1.132 and 1.136.
6. Tex Dept of Health, 25 Tex Admin Code, §1.132.
7. Tex Water Comm, 31 Tex Admin Code, ss330.136 (Subchapter F: Other Operational Standards for Type I, II, III, and IV Sites).
8. 40 CFR 258.28 — Title 40, Code of Federal Regulations, Section 258.28).
9. "The Physician's Guide to Medical Waste Regulations," *Tex Med.* August 1991: 52–55.
10. Dept of Labor, OSHA, 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens; Final Rule. (b) Definitions.
11. Tex Water Comm, 31 Tex Admin Code, §330.5: Definitions in subchapter A: General Information.
12. Dept of Labor, OSHA 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens; Final Rule. (d.4.iii) Regulated Waste.
13. Dept of Labor, OSHA 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens; Final Rule. (g.1.i.I) Communication of Hazards to Employees.
14. Tex Water Comm, 31 Tex Admin Code, §330.1004 (g).
15. Dept of Labor, OSHA 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens; Final Rule. (d.4.iii.C) Regulated Waste.
16. Tex Dept of Health, 25 Tex Admin Code, §1.134 (a).

Court releases opinion concerning abortion

Hugh M. Barton, JD
TMA Assistant General Counsel

The Supreme Court released its opinion in Planned Parenthood of Southeastern Pennsylvania v Robert P. Casey *on June 21, 1992 (1). This decision had been eagerly awaited by both "pro-choice" and "pro-life" advocates, who were concerned about the future of abortion regulation.*

Q: Did the Supreme Court uphold *Roe v Wade* (2)?

A: The court upheld the "central holding" in *Roe v Wade* that:

- recognizes the right of a woman to choose to have an abortion before viability and to obtain it without undue interference from the state (Before viability, the state's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure);
- confirms the state's power to restrict abortion after fetal viability, if the law contains exceptions for pregnancies that endanger a woman's life or health; and
- recognizes the state's legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.

Q: *Roe v Wade* has been controversial since it was decided in 1973. Why didn't the Supreme Court overturn it?

A: The court found that, although *Roe v Wade* is widely disliked by some parts of the American public, it was good law when it was decided, and the passage of time did not diminish the wisdom of *Roe*'s central holding. Furthermore, to overrule *Roe* because it is politically unpopular would undermine the rule of law, as expressed in the principle of stare decisis (3), and render the court a purely political instrument.

Q: Were any modifications made to *Roe*?

A: The court did modify *Roe* to some extent. First, the court rejected the "trimester" framework, because it did not consider it a part of the essential holding of *Roe*. The court found that the trimester framework "misconceives the nature of the pregnant woman's interests" and that "it undervalues the state's interest in potential life."

In light of this finding, the court found that not every law that makes a right more difficult to exercise is an infringement of that right. Only where a state regulation imposes an undue burden on a woman's ability to make that decision, says the Supreme Court, does the power of the state reach into the heart of the liberty interest protected by the due process clause.

Q: What is the practical effect of this modification?

A: While no state can prohibit a woman from making the ultimate decision to terminate a pregnancy before viability, the court will allow a state to enact regulations that create a structural mechanism by which the state, or the parent or guardian of a minor, may "express profound respect for the life of the unborn." Thus, the court held that:

> a state measure designed to persuade her to choose childbirth over abortion will be upheld if reasonably related to that goal.

Regulations designed to foster the health of a woman seeking an abortion are valid if they do not constitute an undue burden.

Q: I understand that the *Planned Parenthood of Southeastern Pennsylvania* case involved regulations of this nature. What were they and how did the court rule?

A: One regulation concerned informed consent. Pennsylvania law requires that, at least 24 hours before an abortion, a physician must inform the woman of the nature of the procedure, the health risks of the abortion and of childbirth, and the probable gestational age of the unborn child. Further, the woman must be informed of state-published material describing the fetus, providing information about medical assistance for childbirth, information about child support from the father, and a list of adoption agencies. The abortion may not be performed unless the woman certifies in writing that she has been informed of the availability of the materials and has been provided with them if she wants them.

This sort of informed consent was generally upheld. The court said:

> . . . we permit a state to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing the state expresses a preference for childbirth over abortion. In short, requiring that the woman be informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term is a reasonable measure to insure an informed choice, one which might cause the woman to choose childbirth over abortion. This requirement cannot be considered a substantial obstacle to obtaining an abortion, and, it follows, there is no undue burden.

Q: Doesn't the informed consent requirement interfere with the physician's rights?

A: The court did not find any First Amendment issue relating to a physician's "right" not to provide the information mandated by the state. As for the place of physicians in this process, the court says:

> On its own, the doctor-patient relationship here is entitled to the same solicitude it receives in other contexts. Thus, a requirement that a doctor give a woman certain information as part of obtaining her consent to an abortion is, for constitutional purposes, no different from a requirement that a doctor give certain specific information about any medical procedure.

Q: Pennsylvania law requires that a woman wait 24 hours before having an abortion. What happened to this requirement? Isn't that an "undue burden" on the patient?

A: No. Although the district court held the 24-hour waiting period to be "unduly burdensome," the Supreme Court upheld the requirement, though the court agreed that it has the effect of increasing the cost and risk of delay of abortions.

Q: But doesn't the waiting period interfere with the physician's prerogatives in such a case?

A: While the waiting period does limit a physician's discretion, the court stated that is not a reason to invalidate the waiting period requirement.

Q: Can a state now require that a married woman notify her husband of her decision to have an abortion before the abortion takes place?

A: No. The challenged Pennsylvania law also had a spousal notification clause for married women. This provision was held to be an "undue burden" and ruled invalid.

Q: On this basis, is a state prohibited from requiring parental consent to an abortion in the case of a minor?

A: No. A parental consent provision for minors is also in Pennsylvania law. This provision was approved, with the proviso that an "adequate judicial bypass procedure" be in place. Pennsylvania law has a judicial bypass procedure.

Q: What about an abortion clinic's records? Can a state require that certain records be kept and that the names of women receiving abortions be reported to the state?

A: Pennsylvania laws require very detailed recordkeeping and reporting for abortion facilities. However, the identity of the woman who has the abortion remains confidential. These provisions were upheld by the Supreme Court.

Q: What is the current Texas law on abortion?

A: Texas law conforms to the central holding in *Roe v Wade*. The Medical Practice Act allows a physician to perform an abortion if:

- the fetus is not viable and the pregnancy is not in the third trimester (in other words, no intentional abortion on a viable fetus during third trimester);
- the abortion is necessary to pre-

vent the death or a substantial risk of serious impairment to the physical or mental health of the woman; or

- the fetus has a severe and irreversible abnormality as identified by reliable diagnostic procedures.

If an abortion is performed on a viable fetus in the third trimester, a physician must make a report to the Texas Department of Health of the medical indications supporting his or her judgment that the second or third exceptions listed above was present (4).

Abortion facilities in Texas must be licensed by the Texas Department of Health, except for hospitals and physicians' offices not used primarily for abortions. Such facilities must submit annual statistical reports about the abortions performed, but the reports do not identify either patient or physician by name (5).

References

1. US Sup Ct, Nos. 91-744 and 91-902.
2. 410 US 113 (1973).
3. "Stare decisis" (from the Latin, "to abide by decided cases") is the legal doctrine that, when a court has once laid down a principle of law as applicable to a certain state of facts, it will adhere to the principle and apply it to all future cases, where the facts are substantially the same.
4. Tex Rev Civ Stat Ann art §4495b, 4.011 (Vernon Supp 1992).
5. Tex Health & Safety Code Ann §245.001–245.016 (Vernon's pamphlet 1992). ★

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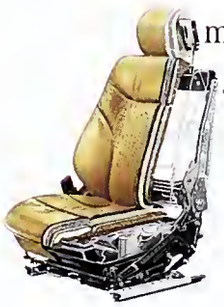

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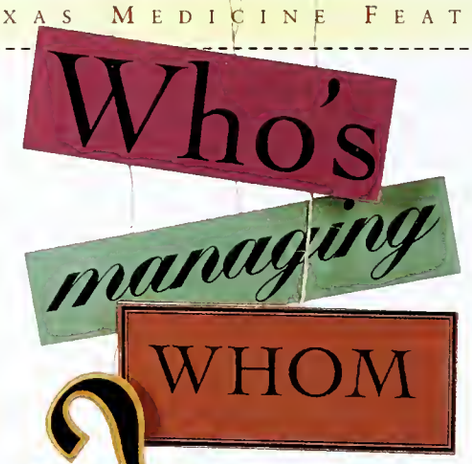

Can Managed Care Control Costs Without Controlling You?

America's $800 billion health-care appetite will take an estimated 14% bite out of the country's gross national product this year.

Alarmed that health-care costs are rising at an estimated rate of four times the national inflation rate, while almost one third of Americans have no health insurance at all, politicians, bureaucrats, think tanks, special interest groups, consumer groups, and elements of organized medicine have dished up a dizzying array of plans to reform the US health-care system.

The centerpiece in most of those plans' cost-containment strategies is managed care.

Mark Richardson, Associate Editor

While the idea of "managing" patients' care is not new — it was first used in the 1940s in California and New York — the move away from traditional fee-for-service care has gained remarkable momentum in recent years. In fact, despite organized medicine's longtime opposition, health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service (POS), and/or managed fee-for-service plans appear poised to become the favored cost-efficient methods of delivering health care in Texas and the United States in the next few years.

Traditionally, a majority of physicians have opposed managed care plans, citing a loss of autonomy in making medical decisions, lower fee payment schedules, and the "hassles" involved with paperwork and utilization review procedures. TMA has for the past few years, through its Managed Care Initiative, worked with insurers to reduce the number of hassles involved with managed care claims and to increase the level of reimbursement. The American Medical Association, in particular, gave managed care the cold shoulder for many years, though it has recently warmed to the concept.

Statistics show an almost inexorable march towards managed care's dominance of health-care delivery. A nationwide survey by SMG Marketing Group of Chicago reveals that traditional fee-for-service patients dropped from 7 out of 8 in 1984 to just 1 in 5 in 1991. The same study projects that by 1997 only 12% of doctor-patient contacts will be on a fee-for-service basis.

Acceptance of that trend by physicians is limited, some consultants say, and it is somewhat divided along generational lines and often based on expectations. Older, established physicians, more comfortable with the traditional system, tend to object to the intrusive nature of managed care, while younger physicians, particularly those who have completed their training in the past decade, often enter the profession in a salaried position with an HMO or other plan.

But some very recent studies indicate that, despite its early promise of cost savings, managed care may be susceptible to the same spiraling costs that have plagued more traditional forms of health care.

Taking it slow in Texas

Managed care has been slow to catch on in Texas, which at the end of 1991 ranked only 28th among the 50 states in terms of the percentage of the state's population enrolled in HMOs, according to InterStudy, a nonprofit health policy research firm that tracks the HMO industry. Texas, the third largest state, has only 8.0% of its population enrolled in HMOs, well below the national average of 14.5%.

"Managed care will grow because it is what employers are demanding."

Other managed care products, such as PPOs and POS plans, are growing at an equal or faster rate both in number and acceptance, according to many experts, though accurate statistics on those products are harder to come by. (See box, p 39, for a definition of the various managed care products.)

John H. Smith, MD, Fort Worth, chairman of the TMA Council on Health Facilities, said managed care, despite the reluctance of many physicians to embrace it, is going to be a large part of medicine's future.

"I think initially there was a great concern among doctors, and resistance to the idea of managed health care because they didn't want to lose their autonomy," he said. "They wanted to still be able to control the care they provide to the patients. I think now physicians are seeing the need for cost control. The public is demanding it. Employers are demanding it. Congress is demanding it. And I think doctors now are making a concerted effort to participate in this."

But, Dr Smith said, many Texas physicians have taken a wait-and-see attitude before participating in managed care.

"I think that if this measure can control costs, we need to make sure it is done in the right way. And done not just to control costs but to also provide as high a quality of care as possible within the restrictions of economics," he said.

Despite its relatively small penetration into the Texas health-care market, the number of people enrolled in managed care plans in Texas is growing rapidly. During the last 8 years, managed care has grown nationwide from 0 to 25% of group health coverage sold by commercial insurers, according to the Winter 1991 edition of *Health Affairs*.

That growth is expected to persist, according to Louis Goodman, PhD, TMA's director of medical economics.

"Managed care will grow because it is what employers are demanding. The rapidity of that growth, I think, has to do with how quickly our economy expands," said Dr Goodman. He added that while the trend is definitely to-

"Right now, the hot things employers are looking at are definitely the point-of-service type products."

wards managed health-care services, there is room for all players in the Texas marketplace. He also cautioned that evaluating the state of managed care in Texas is iffy, because "the managed care services that are the 'hot properties' of today may be nowhere to be found tomorrow.

"I think there will be different players on the market in 5 to 10 years because of the sifting and sorting out in the marketplace," he said. "The big players will be here but the products and services they offer will be different. The service keeps changing. Managed care is a moving target."

State Government Studies Managed Care

The trend towards managed care has been noted, but not necessarily embraced, by the Governor's Task Force on Health Policy, an ad hoc group appointed by Texas Gov Ann Richards to study the health-care system and to make recommendations for change to the 1993 Legislature.

The group's Cost Containment Subcommittee studied several aspects of managed care during months of hearings, but appears to have backed away from recommending it as the cornerstone of the state's cost containment efforts, other than to note in a June 25 report to the task force that managed care appeared to be an appropriate vehicle for coordinating care through case management.

The subcommittee's recommendations to the task force were centered on implementation of a comprehensive insurance reform package. That package would standardize and streamline health-care benefits and management to include a single, standard health policy with few endorsements, a single claim form, a single billing form, and a single application form. (See "Task force report focuses on access, prevention," Legislative Affairs, p 53.)

The Texas Department of Human Services (DHS) is the only government entity in the state with definite plans to use managed care, in part as an attempt to cut costs. As mandated by the legislature, DHS will begin a 2-year demonstration managed care project under the state Medicaid program in 1993.

According to Linda Marstiller, project director for the DHS managed care initiative, the state will conduct two demonstration projects, an HMO model program in Travis County (Austin), and a primary care case management project in Galveston, Chambers, and Jefferson counties.

"We have four primary goals in the project," said Ms Marstiller. "One is to improve access; two is to improve the quality of care; three is to reduce the inappropriate utilization of services; and four is to enhance cost effectiveness."

She said early proposals for the project by the state's Medicaid insurance contractor indicate cost savings, but in her eyes, the primary focus will be in the area of access.

"I believe that the pilot needs to be cost-neutral," she said. "I certainly can't spend any more money, plus I don't have any funding. So the project has to be funded with the existing dollars."

She hopes the pilot program will develop ways to attract more physicians to the Medicaid program.

"Those physicians who participate in the primary care case management model will have a choice of either capitation or the traditional fee for service with a case management fee," she said. "And in the HMO models, of course they receive a capitation on the front end, but there will also be assistance for physicians in managing the care."

She said DHS will gather extensive data during the 2-year project and, based on the data, will recommend whether the Medicaid program should expand the managed care program into selected areas, if not the entire state.

What's Hot, What's Not

According to some experts, the fastest growing segment of the managed care market is the point-of-service plan. John Deane, executive director of UT-MED, The Group Practice of Medicine at The University of Texas Medical Branch in Galveston, said employers are finding POS an attractive cost-saving option.

"If you look at what's growing fastest, it was the HMOs in the early to mid-1980s, and then the PPOs

Defining managed care: What are the options?

Managed care health-care plans come in all types and sizes. Here is a quick explanation of each of the main types:

- *Health Maintenance Organization (HMO):* A prepaid health plan organized in accordance with federal or state regulatory guidelines and usually "qualified" under the federal HMO act. Participants may obtain care only from a specified list of providers. There are four main types of HMOs:
  Staff model: Delivers services through a salaried physician group that is employed by the HMO unit.
  Group model: Contracts with a single independent group practice to provide health services.
  Network model: Contracts with two or more independent group practices to provide health services.
  IPA model: Contracts directly with physicians in independent practice, with one or more associations of physicians in independent practice, and/or with one or more multispecialty group practices to provide health services.

- *Preferred Provider Organization (PPO):* An indemnity plan that operates under a contract with a group of providers for coverage under a special financial arrangement. Plan participants have incentives to use the preferred provider network but may use other providers at the risk of higher out-of-pocket costs.

- *Point-of-Service Plan (POS):* A hybrid plan in which a participant's access to a provider network is controlled by a primary care physician who serves as a gatekeeper for care. Participants may seek care outside the network but at reduced coverage levels. In-network plan design is often similar to an HMO, and the plans are sometimes referred to as open-ended HMOs.

- *Managed Care Indemnity Plan:* A fee-for-service indemnity plan, placing little or no restriction on participants as to choice of providers, but with utilization controls such as precertification of admissions and referrals, and direct reimbursement to providers.

- *Traditional Indemnity Plan:* A straight fee-for-service plan, with no restrictions on participants' choice of physicians or hospitals, with a set annual deductible for minor expenses such as office visits and prescription drugs, and major medical coverage, usually paying 80% of hospital and other major expenses.

have taken off like a rocket in the last few years," he said. "But now the point-of-service product is beginning to take hold and will be the dominant product over the next several years."

Mr Deane said POS is actually a transition product to a more HMO-like system.

"It has a more intense utilization management than the PPO, and it essentially looks a lot like an HMO, except you can go out of the network for 20% or 30% extra," he said, adding that as costs mount, the out-of-pocket cost for participants seeking care outside the network will inevitably increase. "Eventually 20% or 30% becomes 40% or 50%, continues to grow, and one day you have 100% out-of-pocket cost if you leave the point-of-service product.

"And what is that?" he asked. "That's an HMO." He noted that as employers become increasingly willing to restrict the choice of providers for their employees and their dependents, the POS will gradually look more and more like an HMO.

Dennis Copfer, a consultant with Foster Higgins in Dallas, said POS products are indeed "hot" today, but other products also are on the horizon.

"Right now, the hot things employers are looking at are definitely the point-of-service type products," he said. "But also hot, I think, are direct contracting relations. I think the other things that we've started seeing are some coalition purchasing arrangements."

Direct contracting relationships occur when an employer bypasses a third-party insurance carrier and contracts directly with a specific group practice or individual physicians to provide health care for employees, he said. Coalition purchasing involves two or more small businesses combining resources to form a large enough pool of employees to qualify for group health insurance coverage.

Randy Hodde, executive director of the Houston Area Healthcare Coalition, a nonprofit group representing some 50 Houston-area employers on health-care cost issues, said he sees much the same trend.

"We're seeing more point-of-service, more direct contracting in the Houston area," he said. "In addition to reduced overhead and more direct control over expenses, employers see direct contracting as a key component of a continuous quality improvement plan, the concept of developing a continuous relationship with the provider, one that doesn't change every other year. They see that as an important facet of direct contracting."

"In some cities, the average cost per employee for HMO coverage is actually higher than the average cost per employee for indemnity plan coverage."

Does Managed Care Really Work?

With so many employers and the government looking to managed care as a cure for runaway health-care costs, scrutiny of its ability to deliver the promised cost savings has increased. And some studies demonstrate that, in some cases, it may not.

A 1991 Foster Higgins health-care benefits survey noted that, on average, managed care plans cost less than indemnity plans.

"But many individual HMOs, PPOs, and POS plans do not," the survey reported. "Results show substantial variation in cost savings by geographical region. In some cities, the average cost per employee for HMO coverage is actually higher than the average cost per employee for indemnity plan coverage."

One such city is Houston, where Foster Higgins notes that in 1991, companies paid an average cost per employee of $3,180 for indemnity insurance, compared to $3,295 for HMO and $3,606 for PPO coverage.

In comparison, the national average cost per employee is $3,573 for indemnity coverage, $3,335 for PPO coverage, and $3,046 for HMO coverage.

When asked to rate various types of plans, nationally, employers in the survey tended to be less happy with the management aspects of all plans — including the areas of cost control, utilization control, and administrative costs — than they were with quality control elements such as access, benefits, options, and employee satisfaction.

"The wide variation in managed care financial performance underscores an obvious fact: well-run managed care plans save money; poorly run plans do not," the survey noted, adding that more than half its respondents say their HMO rates are generally as high or higher than their indemnity plan costs, and only about a third of PPO sponsors are confident that their plan saves money.

In a series of reports in its July, August, and September 1992 editions, *Consumer Reports* magazine examined health-care costs in the United States, devoting one third of the series to HMOs. The report examined both consumer satisfaction with HMO care and the cost effectiveness of HMOs.

"The HMOs in our survey generally satisfied their members at least as well as traditional fee-for-service practitioners," the report stated. "But when it comes to holding down the nation's $800 billion medical bill, the story of HMOs is less clear-cut."

Consumer Reports notes that most of the cost reductions achieved by HMOs were accomplished by negotiating discounts with hospitals and reducing the number of days patients spend in the hospital. But, the report states, many providers simply shift those cost savings to other users of their services.

"Thus," the magazine states, "a cost shifted by an HMO is not a cost saved for the nation."

Other areas where expenses are hard to control, the report noted, included medical specialists and high-technology diagnostic tools.

Two other recent studies by the Congressional Budget Office (CBO) and the journal *Health Affairs* have questioned the overall cost-effectiveness of managed care plans.

American Medical News (*AMN*) reported in its August 10 issue that research by the CBO concludes that even if all Americans were covered by managed care plans, the effect on cost growth would be relatively small. The CBO study found little evidence that the growth of managed care has curtailed system-wide costs or even the cost to those enrolled in the plans.

The CBO report noted that while group- or staff-model HMOs have had the largest impact on cost containment, the most growth in managed care is in the less restrictive forms, such as PPOs, POS plans, and managed fee-for-service products, which have less effect on controlling costs.

In addition, *AMN* reported that the CBO study points out the biggest cost savings produced by managed care have been squeezed out of hospital costs and to produce further savings, plans will have to find ways to cut costs on ambulatory care.

In a commentary published in the Summer 1992 edition of *Health Affairs*, authors William B. Schwartz, MD, and Daniel N. Mendelson say that optimism by the writers of myriad health-care reform proposals that managed care can contain costs without intrusive government regulation or

Should managed care be part of your practice?

Regardless of whether your gut-level response is to approve of or to oppose managed care, you probably realize that gathering solid information about the various plans is vital before signing with any of them.

With that in mind, the TMA Council on Health Facilities is conducting the Managed Care Review Program, a plan to gather as much information as possible and to represent physicians' concerns with managed care plans.

"We plan to gather information from managed care plans in Texas that will enable a doctor interested in a given plan to determine for himself or herself if that plan's policies are acceptable," said John H. Smith, MD, chairman of the TMA Council on Health Facilities. "We will look at major facets of each plan, such as reimbursement, quality assurance, utilization review and so forth, and provide comparisons with other plans available in a given market to help doctors make an informed choice."

The goal is to create a "level playing field" by providing physicians with as much information possible, he said.

According to Louis Goodman, PhD, TMA director of medical economics, the growth of alternative delivery systems demands that physicians stay abreast of the industry and know about both quality and administrative issues before they participate in any managed care plan.

TMA hopes not only to review the policies of various managed care programs but to encourage them to keep their standards high, he said.

"We are exploring the concept, subject to legal review, of developing policies that we believe quality players should adhere to," Dr Goodman said. "Those policies might address utilization review mechanisms, payment policies, due process procedures, and the availability of a medical director to talk to physicians." Managed care systems would be compared against these quality standards and the results made available to physicians and patients.

A second survey of plan participants will ask physicians about their experiences with the various managed care plans. The compiled data from that survey will be included in TMA's managed care database for review by physicians studying various plans.

The Managed Care Review Program will be studied in detail in November by the Council on Health Facilities, and if approved, will go into effect next year.

Other facets of the review program may include development of a "Do's and Don'ts Guide to Managed Care," a series of workshops, and managed care market profiles developed from information gathered for the managed care database.

The Council on Health Facilities plans to continue its program of face-to-face meetings with managed care providers to present physician concerns over fee disputes, denial of payments, precertification problems, and other "hassles." The council began meeting with carriers in October 1991 and through the process has collected more than 1,000 "Hassle Factor Log" forms from physicians, detailing problems with payments and other aspects of managed care plans and Medicare. By using the data gained through the log forms, the council has been able to present physicians' problems directly to medical directors and administrators of managed care plans and resolve hundreds of problems, Dr Smith said. (See "Managed care hassles not only frustrating, but expensive," *Texas Medicine*, August 1992, p 28.)

"Our main concern in this program is that we act as an advocate for the physician when it comes to managed care issues," said Dr Smith. "We want to make certain that physicians have a strong voice in the way managed care plans are developed and operated in Texas to assure that we can continue to provide high quality medical care."

(For a review of some of the pitfalls to beware when signing a contract with a managed care organization, see "Look before you sign on the dotted line with HMOs and PPOs," *Texas Medicine*, June 1991, pp 54–57.)

sacrifice of medical benefits is misplaced.

According to Schwartz and Mendelson, "While managed care providers historically have had significantly lower costs than other insurers, the rate of increase in their costs has been virtually indistinguishable from that of the fee-for-service sector."

They note, as have several others, that managed care is subject to the same rising cost pressures faced by other providers, namely the inflow of new technology and rising wages. They further point out that, having achieved most of its early cost savings in the reduction of hospital utilization, managed care must now find other methods of costs savings, such as rationing access to the most expensive of services, which may prove unpalatable to patients and politicians alike.

A warming trend from organized medicine

Organized medicine has not always looked so kindly on managed care. For several decades, the AMA was a sworn opponent of managed care and worked active-

What do your colleagues think about managed care?

Physicians are far from reaching consensus on managed care's value as a tool for delivering high-quality, cost-efficient health care. The issue raises questions of autonomy, access to care, and quality of care, along with financial concerns.

Many think managed care plans do indeed have a place in the health-care delivery system, but few physicians wholeheartedly endorse the concept.

"As it's being done right now, it's more of a hassle than anything else," said Hugh Lamensdorf, MD, a Fort Worth urological surgeon and member of the TMA Board of Trustees. "It has, I think, the potential of controlling costs to some extent . . . but I personally think it is being oversold."

He added that "punitive" measures such as utilization review and precertification — "Mother-may-I?" procedures requiring preapproval by the carrier — act as a disincentive to participate in a managed care plan.

"I think that some sort of incentive-based managed care will probably work, but I haven't seen anybody trying to do that yet," Dr Lamensdorf said.

Younger physicians, especially those just entering practice, are much more open to managed care, according to a 1991 survey of medical residents by Merritt, Hawkins and Associates. The survey, which interviewed 100 third-year residents around the country, indicated that 69% of residents prefer a managed care or group setting as their first practice choice. Only 8% of respondents preferred a solo practice, and 5% wanted a partnership.

In addition, 60% of those surveyed preferred a salaried position for their first practice, 20% wanted an income guarantee, and only 15% preferred the traditional fee-for-service payment system.

But Lane Smith, MD, Galveston, a resident in otolaryngology and chairman of TMA's Resident Physician Section, says while younger physicians may see managed care as a viable career option, at least in their early years, their objections to managed care tend to mirror those of their older, established colleagues.

"Young physicians may be willing to go into it to either get the location they want or as a way to get out into private practice to pay off their debts, but the vast majority of the residents I have talked to do not think very highly of managed health care," he said. "The main reason, I think, is the curtailment of your ability to be a doctor. You go into medicine, partly, to be your own boss. You hate to have a businessman sitting behind a desk somewhere deciding that if each plan physician orders 10 fewer chest x-rays, we can save $5,000 next year.

"You want to make the decision right there in your office. You are seeing the patients, and you want to be able to say — right or wrong — 'Maybe I'll order two extra chest x-rays this year, but I feel it's the right thing to do,'" he said. "I think the majority of physicians believe that managed care plans limit their costs by limiting you, and that is a big problem."

Norman Chenven, MD, president of Austin Regional Clinic, the primary provider of HMO services for PruCare of Austin, says managed care will continue to grow as Texas catches up with the rest of the country. He adds that physicians should consider several key points when contemplating practicing in a managed care environment.

"If you live in an urban area, if you are new in practice, if you don't have enough patients, if you are in primary care in a significant urban area where there is a lot of managed care activity, then you are probably going to want to search out a good managed care relationship, or two or three," he said. "A lot will depend on the business community in your city. Some business communities will insist on it, because they want to get some control over the cost of care. Other business communities are not that well organized and it won't matter."

He said a physician's willingness to deal with administrative issues is a critical factor in any decision to participate in managed care.

"In terms of what it means for a doctor, I think working with a managed care organization will mean more administrative involvement," Dr Chenven said. "Sometimes that may mean just handling paperwork;

ly to keep it in the background of medicine.

But recent events signal an acknowledgment by the AMA and some physicians that managed care plans have a place in the spectrum of medical care plans available.

In June, James S. Todd, MD, executive vice president of the AMA, told a meeting of the Group Health Association of America (GHAA), an HMO trade association, that medicine was beginning to see the benefits of managed care plans.

"The AMA has been relatively slow in recognizing and accepting the legitimacy and the benefits of these modes of practices," he said. "And this failure was based on traditional beliefs and conventional wisdom, which, as we all know, is sometimes more conventional than wise.

"So on behalf of organized medicine, let me acknowledge here and now the positive contributions that are made by HMOs and other types of managed care," said Dr Todd. "It is difficult to be ahead of your times, but you have managed it well."

His comments, reported widely in both the popular and medical trade media, were seen by some as an "olive branch" to physicians practicing in HMOs, many of whom have felt disenfranchised by the AMA because of its previous stance against managed care. The GHAA estimates that at least 50% of all physicians have at least one managed care contract connected with their practice.

sometimes it is hassle. That depends on your relationship with the managed care company and how that company runs its business.

"If you have a completely full practice and people are tearing down the door to get in and willing to pay full fee, then there is no reason to get involved in managed care," he said. "If you have space in your schedule, it is better to see somebody at a discount price then nobody at all. So it is very much an individual business decision."

Dr Chenven disagrees with many physicians' contention that managed care plans interfere with their ability to made medical decisions.

"One of the big fears is that someone is going to tell you how to practice medicine and I have not seen that happen in managed care to any great degree," he said. "I have seen hassles where a physician wishes to make a referral and the HMO says we won't pay for it. At that point, the physician has to get involved in negotiating, convincing. Generally speaking, if the decision to refer makes sense, the physician is going to prevail, but at what cost in terms of his time and energy?"

Whether or not a physician can accept some level of interference or is willing to put in the time and effort to deal with the system in managed care plans is a key factor in whether it is right for them, according to a consultant who advises group practices on managed care and other matters.

"It may be difficult for some physicians who don't want to deal with managed care to avoid doing so," said John Deane, executive director of UT-MED, The Group Practice of Medicine at The University of Texas Medical Branch in Galveston. "If you are in a small town in Texas and you're in your fifties, you can probably make it to retirement and not have to worry about it.

"But if you are in, say, Galveston, and you're in your fifties, you are going to find an increasing tension. You might be able to retire and never join a health plan but it's going to be tough, because patients are going to be leaving increasingly, employers are going to be asking 'Why aren't you helping participate in cost containment?' And in the major cities, I just don't think it's an option (to not participate)."

Others echo the sentiment that it will be difficult for many physicians to avoid managed care in the future.

"You can't be bullheaded and go out and say 'I'm going to be a doctor and I'm going to do my own thing," because you just don't have those kind of choices anymore," said Susan Dobbs, MD, a Humble anesthesiologist and chairman of TMA's Young Physician Section. "The government is becoming more and more involved, and with the hassles of the insurance companies and all the other things you have to face, it makes it virtually unheard of to go out on your own and be able to survive."

Most medical students are leaving their training ill-prepared to deal with the business aspects of managed care, according to Mr Deane.

"While younger physicians may be more apt to consider managed care, they may not be ready for it. I think our medical schools have not really changed the curriculum all that much," he said.

Darrell Williams, MD, dean of Texas Tech University Medical School, said his school's curriculum is currently not instructing medical students in managed care issues.

"When our students get to the third and fourth years, they spend a great deal of time on the ward, so they have a practical, hands-on experience with utilization review and some of those issues," he said, "But we really don't have a systematic approach to managed care education. Our (curriculum committee) is investigating the need to change our curriculum to emphasize those areas."

Other medical schools in the state provide some training in economic matters, but overall there is not a lot of discussion of managed care issues. Mr Deane thinks there should be more.

"Most young physicians are taught by older physicians about the profession of medicine and about the physician/patient relationship," he said. "They're not talking about what it means to be a gatekeeper and what it means to have to call an 800 number to get permission to put a patient in the hospital. And so when the physician gets out of school some of them get hit with a ton of bricks."

The AMA officially recognized HMOs in 1978, when its House of Delegates accepted a report saying HMOs delivered the same quality of care as fee-for-service operations, but in the interim the association has done little to promote their growth, often complaining bitterly about the federal government's "unfair" support, both financial and otherwise, for the plans. Today, Dr Todd said, the AMA believes in a "plurality of opportunities" for patients and employers, meaning they have the freedom to choose among several competing forms of health-care delivery.

Predictably, some physicians were not pleased with Dr Todd's remarks.

Ron Brownow, MD, a Los Angeles dermatologist, president of the San Antonio-based Physicians Who Care, said the AMA is not fulfilling its duty to stand up for the majority of its membership — the private practice physicians.

"Instead of praising so-called managed care, the AMA should be insisting that for-profit HMOs inform prospective patients, in advance, how their care will be rationed and how their physicians receive financial incentives when they cut down the number of lab tests they order and specialist referrals they make," he said. "It is an abomination of the highest standards of medical ethics that the AMA would support any system in which patients are limited as

The facet of managed care that physicians appear to object to most is the feeling that they have lost control over how they practice medicine.

to their choice of physician or hospital."

The 3,000-member Physicians Who Care is a group dedicated to the preservation of private practice.

The TMA House of Delegates was a little ahead of the national organization in recognizing that a variety of types of health insurance can be good for the health-care system. In 1989, it adopted official policy supporting multiple approaches to health-care delivery:

> "A variety of health care delivery plans offers to patients the greatest freedom of choice and the best opportunity for further improvements in health care. A patient should be free to select the physician, insurance company, or type of policies which he or she prefers. The physician, in turn, except in an emergency, is free to select the patients whom he or she will serve, to accept or not accept reimbursement from a third party, and to participate or not to participate in any type of legal insurance contract. Multiple systems of medical care delivery, such as fee-for-service and prepaid, and multiple kinds of insurance contracts, ie, indemnity, service or participating physician contracts, are acceptable arrangements between physicians and third parties for delivery of and payment for medical services."

Who's in control?

The facet of managed care that physicians appear to object to most is the feeling that they have lost control over how they practice medicine.

Hugh Lamensdorf, MD, a Fort Worth urological surgeon and member of TMA's Board of Trustees, says the danger in managed care arises when unqualified people make medical decisions. Most physicians (in managed care or not) have experienced trying to convince a non-MD reviewer to approve a medical procedure.

"You're talking to somebody who doesn't know a whole lot about medicine, who doesn't understand what it's all about, and you have to convince them to let you do something," Dr Lamensdorf said. "When that happens, you either end up with some uninformed, untrained person telling a doctor that he can't do something or with the doctor convincing them that he should do it. You don't reach an intellectual decision."

TMA's Louis Goodman says while managed care has brought some positive elements to health-care delivery — additional career choices for physicians, different levels of service and price for patients, increased access to care, and some cost savings — physicians must be wary when managed care is used solely as a cost-cutting tool.

"We can't assume that quality will always be a part of the equation," Dr Goodman said. "We must work as an association to assure that standards are put in effect to protect patients and physicians so that the quality of health-care services managed care provides remains high."

John Deane of UT-MED at UTMB advises physicians to get control of managed care programs now or forfeit command over their careers in the future.

"My advice to younger physicians would be to plan on managed care being a major part, if not the dominant part, of their practice and organizing themselves into self-contained, self-regulated, physician-driven organizations to preserve some sense of physician autonomy in the practice of medicine," he said. "I mean, if you're going to have managed care, and you're going to be a physician in a managed care system, it is a lot more satisfying to be in a system that is owned, governed, and driven by physicians than in a system owned, governed, and driven by a third party insurance carrier." ★

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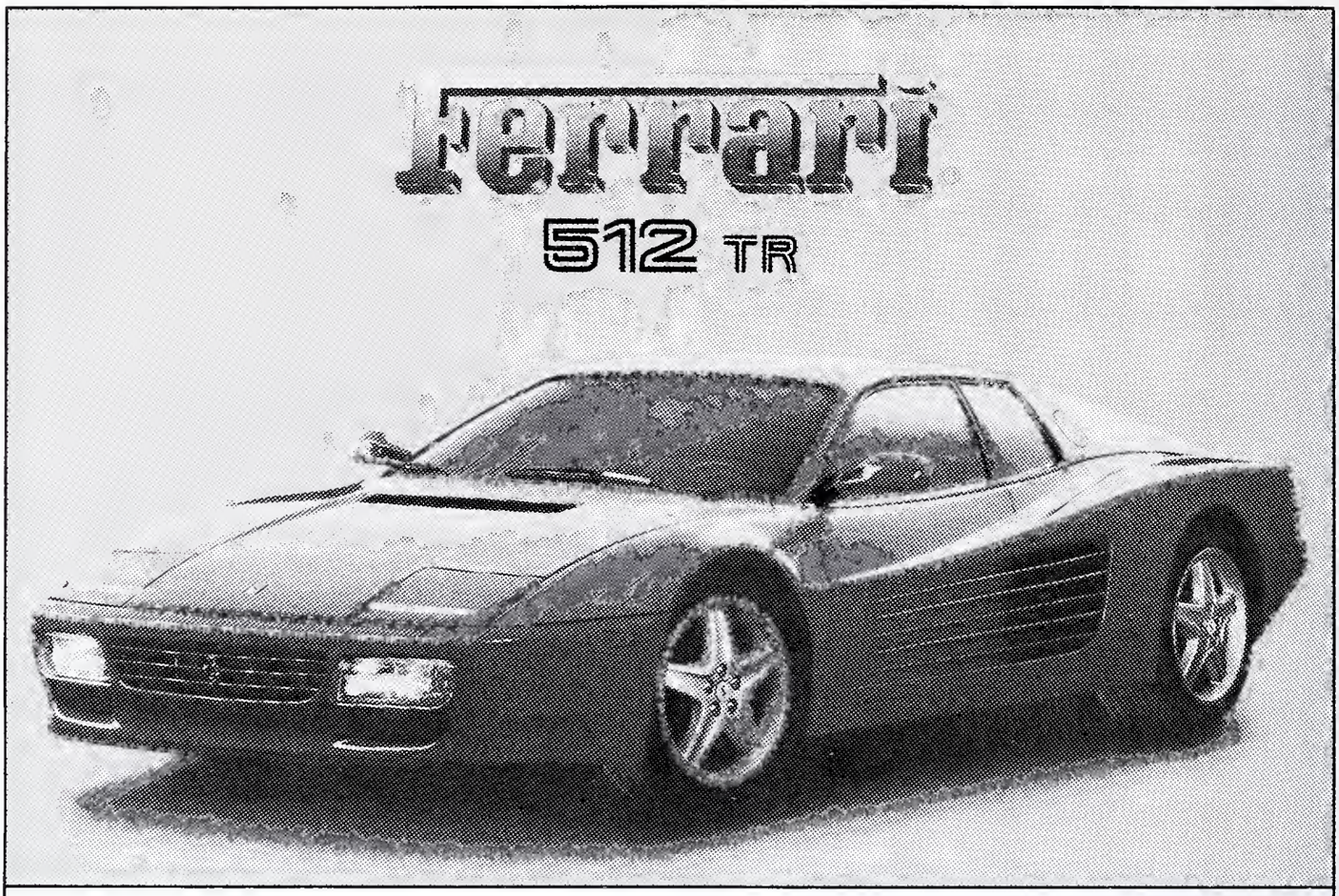

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Name of Prospective Insured Dependent

Doctor's Name

Residence Address

City/State/ZIP

Office Phone (To be used only if added info is needed)
( )

Current Medical Specialty(ies)

Former Medical Specialty(ies) (for past 10 years)

List surgical procedures routinely performed

State(s) where currently licensed

States where formerly licensed (for past 10 years)

Amount of Professional Liability Insurance now carried
$

Is the doctor involved with delivery of babies? ☐ YES ☐ NO

Medical Economics

Physician office labs should prepare for CLIA inspections

MOST PHYSICIANS WHO TEST specimens in the office have by now become certified or obtained a waiver under the Clinical Laboratory Improvement Amendments (CLIA), but unfortunately, simply sending in your check and getting a certificate does not end the process.

According to the Health Care Financing Administration (HCFA), inspections of physician office labs may begin any time after the September 1, 1992, CLIA registration deadline, though they are more likely to begin after January 1, 1993.

"Any laboratory that does anything other than waived tests will be inspected by CLIA at some time during the next 2 years," said Donna Kinney, CLIA specialist for TMA's health care financing department.

Physicians' office labs will be given 3-day notice of a CLIA inspection, unless a problem is suspected or a complaint has been received. HCFA's original intention to routinely perform unannounced inspections met with vigorous protests from the AMA, TMA, and others, citing the potential disruption of patient care and the added costs of locating key lab personnel if they are unavailable at the time of an inspection.

In a victory for organized medicine, Health and Human Services Secretary Louis Sullivan, MD, canceled the provision for the majority of unannounced inspections just before the September 1 start of CLIA.

HCFA has stated in the past it will protect labs that are attempting "in good faith" to comply with CLIA requirements.

"That means that, on first inspection, CLIA will not likely impose monetary penalties on a lab it finds out of compliance," Ms Kinney said. "However, all the principal sanctions may still be used when an inspector finds conditions that warrant them."

Principal sanctions include suspension, limitation, or revocation of any type of CLIA certificate.

"This means that an inspector can shut down a physician's office lab testing after a first inspection," Ms Kinney said.

The vast majority of physician office labs are the so-called moderate complexity labs. The major areas inspectors will be examining in the labs are:

- *Patient test management systems* — Each lab must have a written system for proper patient preparation; specimen collection, identification, preservation, transportation, and processing; and accurate result reporting.
- *Quality control standards* — Written quality control standards must exist for each lab, specifying manufacturers' instructions for all instruments, a procedure manual for lab operations, procedures for performing and documenting calibration of equipment every 6 months, plus a variety of other control procedures.
- *Personnel requirements* — All moderate complexity labs must have personnel to fill the roles of laboratory director, technical consultant, clinical consultant, and testing personnel. One person may fill several or all of the roles if they are appropriately qualified and the staffing level is adequate for the testing volume. There are written qualifications for all the above lab roles.

TMA's health care financing department has prepared a package of materials to assist physician office labs in complying with CLIA regulations. The package, "CLIA Compliance: A Self-Learning Manual/Audiotape Program" contains a guide to CLIA regulations with pertinent information taken from the *Federal Register* and outlines the components with which office lab staff need to comply.

The package also contains an audiotape of TMA's highly successful

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

Physicians get grace period on CLIA claims

UNDER AN AGREEMENT with HCFA, physician office labs will not be denied a Medicare claim for laboratory services submitted prior to December 1 for lack of a CLIA registration form or a CLIA number. Most state Medicaid programs, including Texas, will comply with the revised rules.

HCFA Administrator William Toby, who agreed to the 90-day extension (from September 1) in response to pressure from the AMA and TMA, encouraged physicians who have not yet become registered to use the time to do so. For information on CLIA registration, contact TMA's CLIA specialist, Donna Kinney, at (800) 880-1300 or (512) 370-1422.

seminar series on CLIA compliance. In addition, physicians buying the package will have access to the CLIA Information Service, which will provide regular updates as changes develop that are relevant to CLIA certification, information on accrediting entities, and changes in regulations.

The cost for the CLIA Compliance Manual, complete with audiotapes and the CLIA Information Service, is $89 for TMA members and $165 for nonmembers. To order, mail a check or credit card information to Texas Medical Association, Practice Management — Publications, 401 W 15th St, Austin, TX 78701. To order by phone, call (800) 880-1300, ext 1411 or (512) 370-1411.

TMF issues guidelines for CHAMPUS peer review

THE TEXAS MEDICAL Foundation (TMF) was awarded the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) regional contract for medical peer review by the Department of Defense earlier this year. Since TMF began implementing the new contract on May 1, 1992, several procedures have been put into place that physicians who deal with CHAMPUS patients should be aware of, according to Phil Dunne, executive director of TMF.

The TMF, which formerly provided CHAMPUS review for the state of Texas, has now taken on responsibility for a six-state region: Texas, Arkansas, Kansas, Louisiana, Missouri, and Oklahoma. TMF reviews inpatient services provided to CHAMPUS beneficiaries in acute-care civilian hospitals and rehabilitation units, including hospitals participating in coordinated care and

Codes requiring CHAMPUS preauthorization

CHAMPUS requires preadmission/preprocedure authorizations for the following ICD-9-CM codes:

Simple pneumonia

485	Bronchopneumonia, organism unspecified
486	Pneumonia, organism unspecified
487.0	Influenza with pneumonia

Bronchitis/asthma

466.0	Acute bronchitis
466.1	Acute bronchiolitis
490	Bronchitis, not specified as acute or chronic
491.0	Simple chronic bronchitis
491.9	Unspecified chronic bronchitis
493.00	Extrinsic asthma w/o status asthmaticus
493.10	Intrinsic asthma w/o status asthmaticus
493.90	Asthma, unspecified w/o status asthmaticus
493.01	Extrinsic asthma w/ status asthmaticus
493.11	Intrinsic asthma w/ status asthmaticus
493.91	Asthma, unspecified w/ status asthmaticus

Coronary artery bypass graft

36.10	Aortocoronary bypass for heart revascularization, not otherwise specified
36.11	Aortocoronary bypass of one coronary artery
36.12	Aortocoronary bypass of two coronary arteries
36.13	Aortocoronary bypass of three coronary arteries
36.14	Aortocoronary bypass of four or more coronary arteries
36.15	Single internal mammary-coronary artery bypass
36.16	Double internal mammary-coronary artery bypass
36.19	Other bypass anastomosis for heart revascularization

Angioplasty/endarterectomy

36.01	Coronary (balloon, single vessel)
36.02	With thrombolytic agent infusion
36.05	Multiple vessels
38.12	Endarterectomy — head and neck

Cardiac catheterization

37.21	Right heart cardiac catheterization
37.22	Left heart cardiac catheterization
37.23	Combined right and left cardiac catheterization
88.55	Coronary arteriography — single catheter
88.56	Coronary arteriography — two catheter
88.57	Other and unspecified arteriography

Gastritis/dehydration

267.5	Dehydration
535.00	Acute gastritis w/o hemorrhage
535.30	Alcoholic gastritis w/o hemorrhage
535.50	Unspecified gastritis and duodenitis w/o hemorrhage
552.3	Diaphragmatic hernia w/ obstruction
553.3	Diaphragmatic hernia
558.9	Other and unspecified noninfectious gastroenteritis and colitis

Abortion

Contact TMF for specific coding instructions. CHAMPUS coverage for abortions is prohibited by law except where the life of the mother would be endangered if the fetus were carried to term.

children's hospitals in the region.

According to Mr Dunne, physicians dealing with CHAMPUS patients need to keep four main areas in mind:

- the correct phone numbers to call for information and review;
- the information that must be provided to TMF;
- the diagnoses and procedures that require prior authorization; and
- the timing of the review request.

Judith Martin, TMF director of communications, said that while most of TMF's review activities are initiated through case selections obtained from CHAMPUS carrier claims data, preadmission or preprocedure review actually begins with the physician.

In the review, TMF determines the medical necessity and appropriateness of the setting for inpatient admissions for selected principal diagnoses and for selected procedures (see list), regardless of whether the procedure is principal or secondary. In addition, she said, the need for preadmission/preprocedure authorization exists regardless of whether the beneficiary's CHAMPUS coverage is primary or secondary.

To receive a treatment authorization number, the physician or office staff must call TMF at (800) 299-3627 prior to the admission, before the procedure, or within 2 working days of an urgent or emergency admission or procedure. For questions about which procedures must be preauthorized or any other general questions about CHAMPUS preauthorization, call (800) 299-8963.

When calling for authorization, be prepared to supply TMF reviewers the following information:

- the beneficiary's full name, CHAMPUS identification number, age, and date of birth;
- date of admission or procedure;
- hospital name and provider number;
- physician's name, UPIN, and telephone number; and
- pertinent medical information that substantiates the beneficiary's medical need for the admission or procedure.

Preadmission or preprocedure authorizations may be obtained up to 30 days in advance, and treatment numbers assigned by TMF remain valid for 30 days from the date the original admission or procedure was scheduled. TMF must be notified if the hospital, surgical setting, or physician changes. If the admission or procedure is not performed within 30 days, TMF must reauthorize the procedure or admission.

Ms Martin said that if a CHAMPUS admission or procedure takes place outside the date window and TMF is not notified, or if a treatment authorization number is not obtained, the CHAMPUS carrier will pay the claim but the case will automatically be selected for TMF's retrospective review of the medical record.

For general information about CHAMPUS (other than authorization information), contact the CHAMPUS carrier, Wisconsin Physicians Services, at (800) 388-6767. There are also three local offices in Texas: Central Texas (San Angelo) (915) 942-1292; North Texas (Springtown) (817) 523-5553; and South Texas (San Antonio) (512) 545-9078. ★

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Legislative Affairs

Senate races unsettled by redistricting dispute

TEXAS SENATE ELECTION campaigns have been turned into a high-stakes game of musical chairs by what has become a partisan battle over which set of district lines to use for the upcoming November general election.

As *Texas Medicine* went to press, it appeared a court-imposed redistricting plan favored by Republicans was the likely winner, but the matter appeared destined to be settled by the US Supreme Court. The ultimate outcome will have a significant impact on who the candidates are in several Senate races, including some key races being watched closely by the Texas Medical Association Political Action Committee.

The dispute revolves around two plans to divide the state into 31 senatorial districts — one drawn by a three-judge federal court panel in Austin and the other by the Texas legislature. The court plan, which is favored by Republicans, was used in the March Democratic and Republican primaries after a legislative plan drafted in 1991 was declared invalid. In a special session called late last year, however, the legislature drew up another plan that recently won approval of a federal court panel in Washington, DC.

On August 6, Texas Secretary of State John Hannah, the state's chief election officer, announced that the November elections would be held under the newly approved legislative plan.

"After consultation with the attorney general, it is our belief that it is the only legal option I have," Mr Hannah said in a prepared statement. "I also believe it is the only practical thing to do to provide certain and stable representation to the citizens of Texas for the next several years and, perhaps, to save the taxpayers of Texas millions of dollars in legal expenses."

That action immediately was appealed to the Austin federal court by Republican Party officials, and on August 21 the Austin court ruled that its plan must be used in November. State Democratic Party Chairman Bob Slagle said he will appeal the ruling immediately to the US Supreme Court, but no appeal had been filed by the beginning of September.

Attorney General Dan Morales also announced he would appeal the case but would not necessarily seek action on the appeal prior to the November election.

"We will appeal for the purpose of protecting the integrity of the legislature's plan for future elections," said the attorney general's spokesman Ron Dusek.

Both sides contend that their plan is most favorable to minorities, but the Republicans add that use of district lines in the November election different from those used in the primaries would disenfranchise thousands of voters who would be voting in different districts than those in which they cast ballots in March.

The Democrats argue that use of the court plan in November would disenfranchise those voters anyway because the legislative plan will become law January 1 regardless, and thus senators elected under the court plan would no longer represent the districts that elected them.

According to political consultants from both parties who spoke at the TMA Public Affairs/TEXPAC retreat in August, the debate is over whether Republicans can gain a large enough voting bloc — either by themselves or in coalition with conservative Democrats — to block legislation from reaching the Senate floor and increasing their collective bargaining power with the Democratic leadership.

The attorney general's decision not to seek a quick appeal signals that the court-drawn plan is likely to prevail. Should the legislative plan prevail in the courts, however, the current Senate races would be thrown into chaos.

For example, in Senate District 2, Democratic incumbent Ted Lyon of Rockwall no longer would be facing Republican Florence Shapiro, whose home in Collin County is taken out of District 2 under the legislative plan. Instead, Senator Lyon would face a candidate chosen by the State Republican Executive Committee. A similar fate would befall Republican Gene Shull who is challenging incumbent Sen Bill Haley in District 3 in East Texas.

Perhaps the most bizarre scenario would play out in several districts involving San Antonio and West Texas. Under the legislative plan, incumbent state Rep Greg Luna of San Antonio would jump from District 19 to District 26. Fellow Democratic state Rep Frank Madla would move from District 24 to District 19 and current Sen Temple Dickson of Sweetwater would take over in District 24. Senator Dickson was paired with fellow incumbent Bill Sims of San Angelo under the court plan and was defeated in the March primary.

Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs section of* Texas Medicine.

LEGISLATION ON MEDICARE PAYMENTS FOR EKGS ADVANCES

LEGISLATION TO REQUIRE Medicare to pay for interpretation of electrocardiograms gained approval in the US House of Representatives in August.

The measure passed the House as an amendment to HR 3837, the Federal Program Improvement Act of 1992. The amendment was offered by Rep Henry Waxman (D-Calif).

Meanwhile, separate provisions on EKGs, to terminate Medicare fee reductions for new physicians, and to correct problems with the geographic practice cost index have been approved by two House committees. Action on similar legislation was expected in the Senate Finance Committee sometime after Labor Day.

Texas Medical Association reiterated its support for both the EKG and new physician provisions in a letter to US Sen Lloyd Bentsen dated August 5. In that letter, TMA President William G. Gamel, MD, Austin, also cast doubts about Health Care Financing Administration estimates of the cost impact of that legislation.

HCFA has estimated passage of the proposals would require a 4% cut in 1993 Medicare physician payments.

"We are particularly disturbed by the very wide gap between HCFA's estimates of the cost of these changes and estimates prepared by the American Medical Association and the American Society of Internal Medicine," Dr Gamel stated.

AMA, ASIM, and the American Academy of Family Physicians also are supporting the changes.

Task force report focuses on access, prevention

A DRAFT HEALTH-CARE REFORM plan released in late August by the Texas Health Policy Task Force emphasizes expanded access and increased preventive care.

Fred F. Castrow II, MD, Houston, chair of the Council on Legislation, said the association is pleased with the direction in which the task force is heading.

"It appears that the forthcoming recommendations will focus on a comprehensive benefits package for all Texans, with a strong emphasis on primary and preventive care," Dr Castrow said. "These recommendations will be strongly supported by TMA, as will many of the insurance reform recommendations expected to be included in the report."

The report was released August 27, with a 30-day public comment period to follow. The final task force report is scheduled to be presented to Gov Ann Richards on November 1.

A proposal to recommend a single-payor system garnered considerable attention when the task force met in late August to finalize its report. However, the panel did not recommend that step. Instead, it recommended continuation of the present multiple-payor system (with a mix of public and private payors) but suggested that the state consider utilizing a single-payor system in the future.

During hearings in early August, the task force approved recommendations to develop a comprehensive benefits package with emphasis on preventive and primary care. Such a package might include well baby care, well child care, pregnancy-related care, diagnostic and screening services, and more.

Another proposal includes expansion of Medicaid to cover all children and pregnant women regardless of income. That proposal would require $1.7 billion in new state spending, plus an additional $3 billion in federal matching funds.

The task force, however, did not include recommendations to require all physicians to accept Medicaid and Medicare patients. TMA supports giving red-tape reductions and reimbursement reforms already instituted in these programs a chance to work and increase physician participation.

Among insurance reforms included in the report are proposals to phase in coverage of preexisting conditions; develop a reinsurance pool; require community rating for premiums; strengthen laws on insurance company reserves; and standardize and streamline health-care benefits and management through use of one standard health policy with few endorsements, one claim form, one billing form, and one application form. Recommendations also include premium increase limits, incentives for healthy activities, and establishment of mechanisms for negotiated rate regulation and elimination of cost-shifting.

The draft report also recommends several tort reform and cost containment measures. One issue that has not been resolved is that of physician ownership of medical facilities and self-referral. TMA supports requiring physicians to fully disclose ownership and self-referral relationships to patients. However, the association believes proposals to require divestiture might adversely affect access to services in rural and underserved areas where facilities might not exist without physician investment.

TEXPAC launches grassroots efforts in court campaigns

WHY SHOULD YOU, AS A physician, get involved in the political campaigns for Texas court seats this fall?

In "The Bradley Story," a new video produced by the Texas Medical Association Political Action Committee, Bernard Brian Bradley, MD, gives 20 million good reasons. (Dr Bradley currently is facing a $20 million malpractice judgment for trying to save two patients of another physician.)

The Bradley video, along with a video on the 1992 Texas Supreme Court campaigns and several printed pieces, are part of a grassroots campaign launched during the biannual TMA Public Affairs/TEXPAC retreat held in Austin in August.

The videos are being distributed through county medical societies for viewing at county society, TMA Alliance, and hospital medical staff meetings. The campaign also will include slate cards featuring TEXPAC-endorsed candidates for the Texas Supreme Court, patient education materials, and other items that can be distributed through county societies, alliances, or individual physician offices.

The judgment against Dr Bradley was handed down in March in what TMA public affairs director Kim Ross said was indicative of the "Texas judicial principle that no good deed goes unpunished."

Dr Bradley, a Pasadena pulmonologist, was sued along with the rest of an emergency room rescue team called in to try to save two liposuction patients of a Pasadena obstetrician/gynecologist. Dr Bradley spent 12 hours attempting to stabilize the patients' conditions. One lived and one died.

During the trial, the judge — a former trial lawyer lobbyist — refused to separate the cases against the initial physician and the rescue team members. Because the obstetrician/gynecologist had no resources and no insurance, the plaintiff's attorneys went after Dr Bradley and the other rescue team members under the doctrine of joint and several liability, which allows anyone found partially liable for damages to be held responsible for the full amount of a judgment.

Despite testimony from seven expert witnesses that Dr Bradley provided superior care, he and the others were found liable for the entire judgment.

"If you practice medicine in Texas you too could be a target," Dr Bradley says. "A physician who does a job conscientiously and well and gets it all right can still be liable for $20 million.

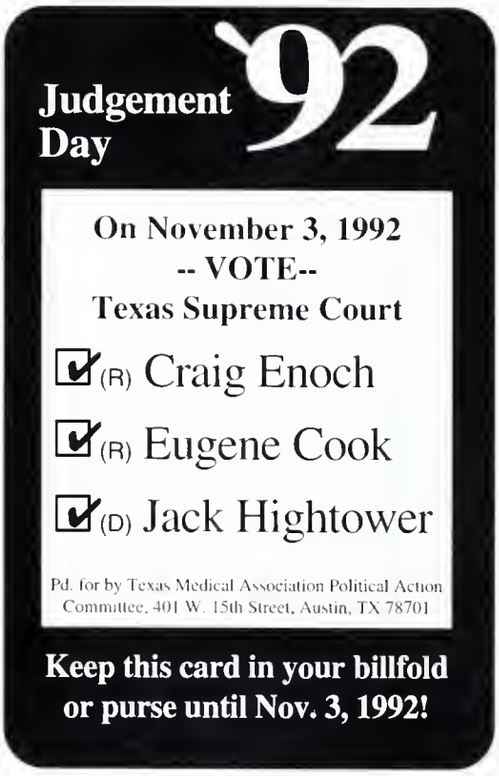
"Doctors simply must be involved" in the political process, he adds. "To prevent this kind of thing from happening again, we've got to get involved."

The second video, "The Fight to Defend the Court," outlines TEXPAC's successful efforts in the 1988 and 1990 state Supreme Court races and profiles the 1992 campaigns. TEXPAC has endorsed incumbents Eugene Cook, a Republican, and Jack Hightower, a Democrat. TEXPAC also is supporting Dallas appellate court judge Craig Enoch, a Republican, against incumbent Democrat Oscar Mauzy.

To obtain copies of TEXPAC's Supreme Court election videos, slate cards, patient information brochures, newspaper advertisements, and other important materials, contact TEXPAC at (800) 880-1300 or (512) 370-1362. TEXPAC's fax number is (512) 370-1633.

Contributions to Texas Medical Association PAC (TEXPAC), Texas Medical Association PAC-Statewide (TEXPAC-Statewide), and American Medical Association PAC (AMPAC) are not deductible as charitable contributions for federal income tax purposes.

Voluntary political contributions to TEXPAC are shared with AMPAC. Contributions are not limited to any suggested amount. Neither TMA or AMA will favor or disadvantage anyone based on the amounts or failure to make contributions. Contributions to TEXPAC and AMPAC are subject to Federal Election Commission regulations. Federal election law prohibits TMA from soliciting donations from persons who are not in its solicitable class (eg, TMA members and their families). All donations received from persons who are not in TMA's solicitable class will be returned.



Teen smoking, state schools to be subject of legislation

KEEPING CIGARETTES OUT of the hands of teenagers and blocking the closure of two

state schools for the mentally retarded are goals of two pieces of legislation that will be debated by the 73rd Texas Legislature in 1993.

In late July, the Texas Board of Health adopted a resolution calling for a three-part attack on teen smoking. The first part of the plan calls for a ban on tobacco vending machines, elimination of free cigarette samples, and revocation of the state tobacco sales permit of any retailer who sells tobacco to minors. The second proposal would establish minimum standards for smoking in public places and work sites. The third would increase state taxes on tobacco products.

The proposals also are supported by the Texas Partnership for Tobacco Prevention and Control, of which Texas Medical Association is a member. The coalition is looking for legislative sponsors.

TMA supported several of the initiatives, including limits on tobacco vending machines, during the 1991 legislative session.

State Rep Doyle Willis (D-Fort Worth) also has announced he will file legislation to prevent the closure of state schools for the mentally retarded in Fort Worth and Austin.

The two schools are scheduled to be closed as part of a federal court settlement in a long-standing lawsuit against the Texas Department of Mental Health and Mental Retardation. Passage of Representative Willis' bill would jeopardize that settlement and likely throw the case back into the courts. ★

All articles in Texas Medicine *that mention Texas Medical Association's stance on state legislation are defined as "legislative advertising," according to Tex Govt Code Ann §305.027. That law requires disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in* Texas Medicine: *Robert G. Mickey, Executive Vice President, TMA, 401 W 15th St, Austin, TX 78701.*

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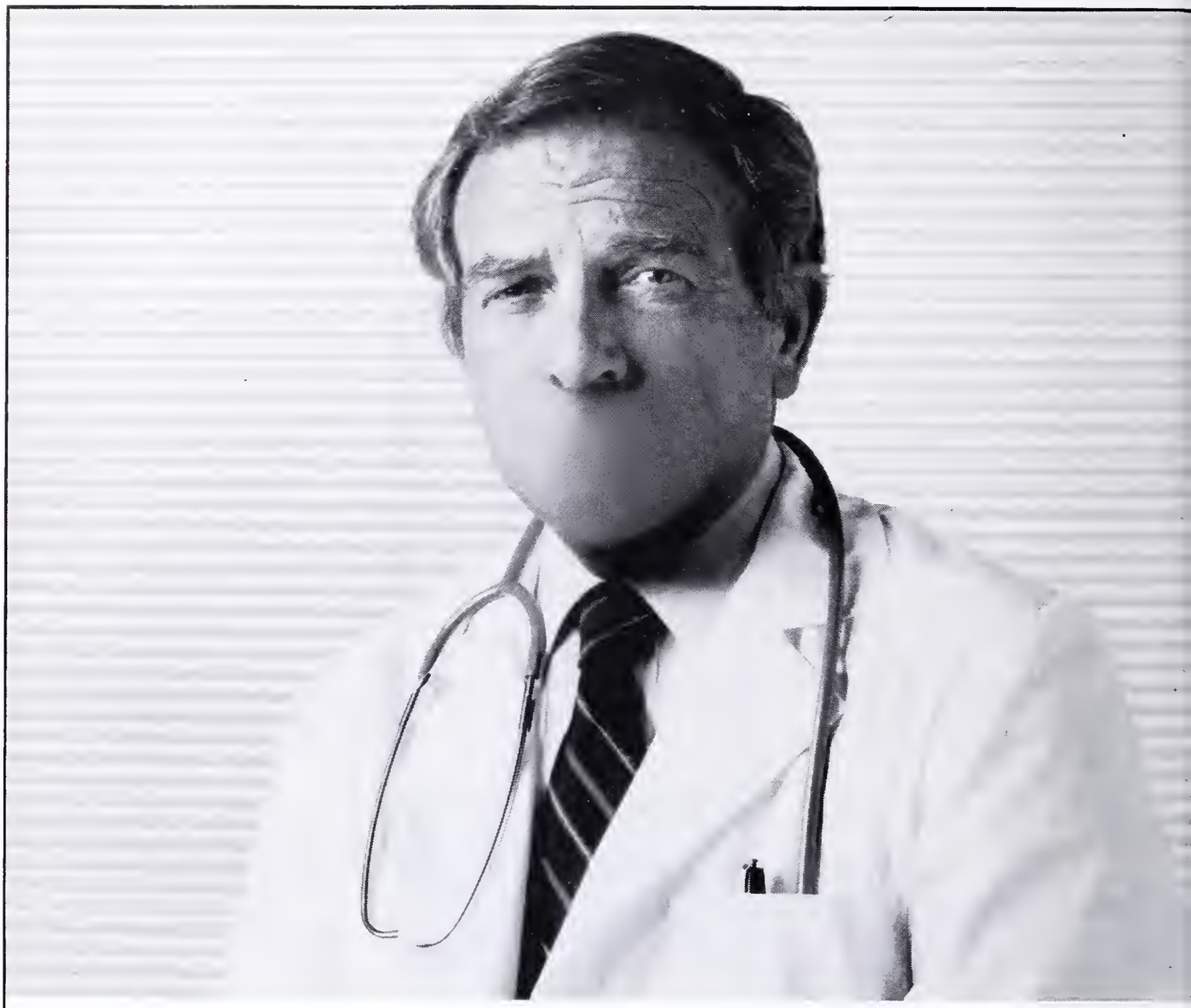

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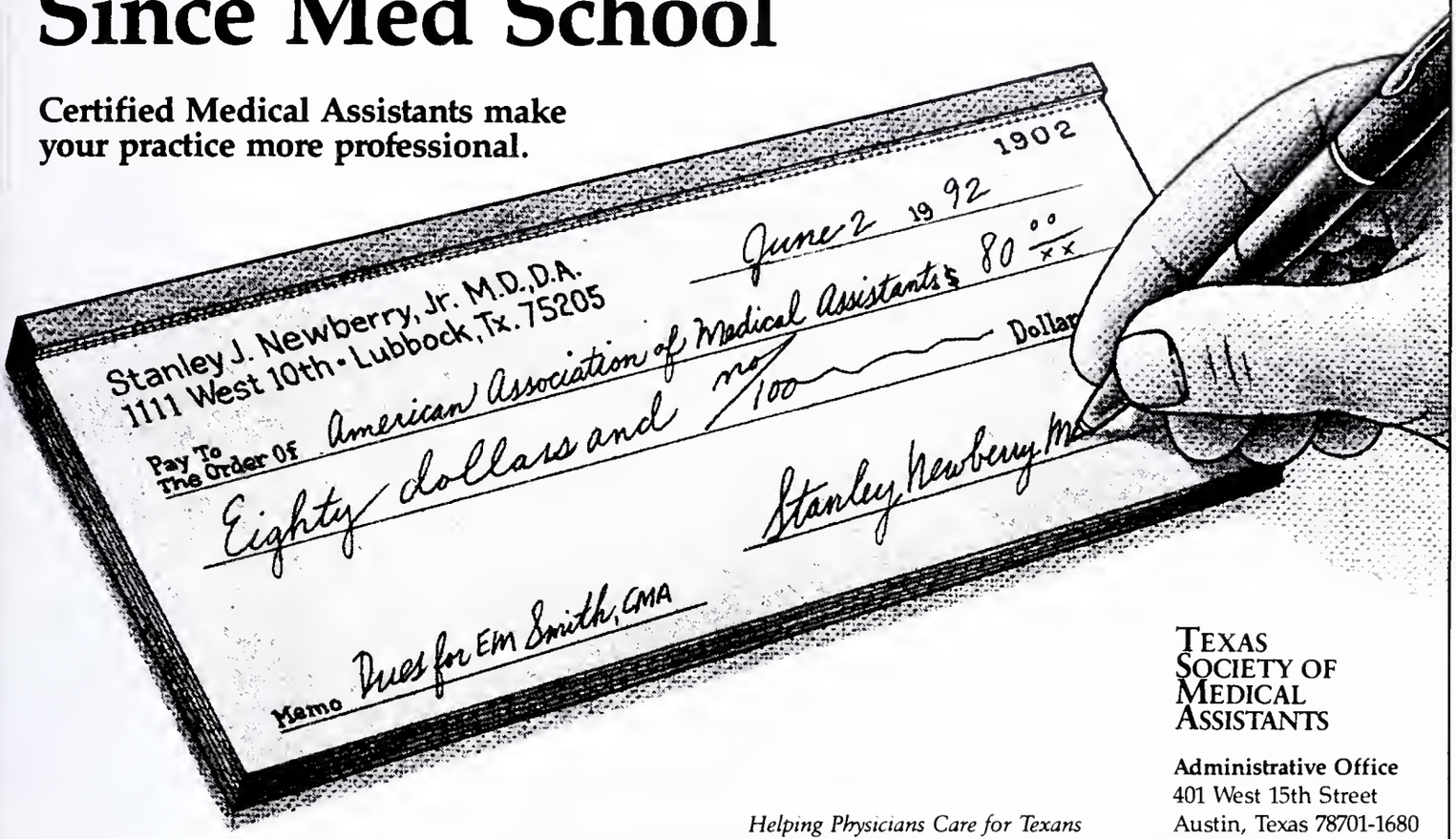

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Public Health

POEP to increase proactive stance against cancer

An expansion of educational resources along with a proactive stance against cancer will be part of the Physician Oncology Education Program (POEP) during the coming year. POEP is administered by Texas Medical Association and funded by the Texas Cancer Council (TCC).

A TCC grant for more than $340,000 was approved to fund POEP for fiscal year 1993, which began September 1.

To help decide the direction of the program, a 6-month evaluation was conducted by consultants from the American Medical Association, American Association for Cancer Education, and Baylor College of Medicine.

"It was time to evaluate the program after its 5 years of existence to help determine the future of the POEP," says Catherine Edwards, PhD, director of the POEP program and head of the TMA public health and scientific affairs department.

Program changes as a result of the evaluation include:

- Marketing POEP education resources on the national level. Materials such as the CARE box, which contains cancer education material, will remain free of charge to Texas physicians.
- Assuming a more proactive stance by making cancer education programs and resources available to physicians in less served areas around the state. Technical assistance will be given to the small provider to implement the programs. Cancer education scholarships will be offered to rural and public health physicians to attend programs in Texas.

POEP was created in 1987 by TMA to meet Texas Cancer Plan recommendations relating to cancer education for physicians. For additional information on the program, contact TMA at (800) 880-1300 or (512) 370-1466.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

Applications for TMA cancer education programs available

TMA's Physician Oncology Education Program (POEP) is now accepting applications for implementation of cancer education programs for the fiscal year that began September 1.

The POEP provides funding for programs designed to educate primary care physicians, residents, and hospital staff in the areas of cancer prevention, screening, and early detection.

The following are descriptions of the education programs and eligibility requirements:

- Hospital Staff: Program incorporates cancer control component into hospital staff meetings. POEP will assist hospitals to implement the program through small contracts and provision of materials. Reimbursement up to $500 is available to offset program expenses. Texas hospitals must apply by April 1, 1993.
- Primary Care Physicians: Program for primary care physicians with special focus on funding programs in Wichita Falls, Abilene, San Angelo, Del Rio, Laredo, McAllen, Harlingen, Corpus Christi, Victoria, Temple, Waco, College Station, Denison, Sherman, Texarkana, Tyler, and Lufkin. Reimbursement up to $2,500 is available to offset expenses. Accredited CME providers in Texas must apply by April 1, 1993.
- Residents: Program requires that contractors be existing, accredited postgraduate medical education providers in Texas. Each contractor should be actively involved in the education of residents and have qualified expertise in the area of cancer, either within their organization or through arrangements with other qualified organizations. The POEP provides reimbursements up to $1,000 to offset program expenses.
- Innovative Programs: Contracts will be awarded that foster and test state-of-the-art instructional approaches to physician education such as computer-assisted approaches, satellite telecommunications, rural area programs, physician self-assessment, interactive video, and community hospital programs. Reimbursement not to exceed $15,000. Applications should be submitted prior to February 1, 1993.

Submission requirement packets for these programs are available from the Project Manager, Cancer Education Program, Texas Medical Association, 401 W 15th St, Austin, TX 78701, (800) 880-1300 or (512) 370-1466.

AGENDA ON AIDS

Many of my patients are putting off elective surgery because of their concern about the safety of the blood supply. Just how likely is it that one could get HIV infection from a transfusion?

Testing will reveal the presence of HIV antibodies in a transfusion unless the donor has been infected within the last few months. The likelihood of a unit of blood being infected is related to the incidence of infection in the donor pool. The best estimates place the chances of a unit of blood being infected at somewhere between 1 in 40,000 (high incidence areas) and 1 in 200,000 (low incidence areas).

Richard M. Grimes, PhD, director of the AIDS Regional Education and Training Centers for Texas and Oklahoma at The University of Texas at Houston School of Public Health, will provide answers to questions about HIV infection and AIDS each month in this column. For further information about this topic or any HIV topic, call the AIDS Helpline for Health Professionals at (800) 548-4659.

TMA conference to focus on clinical management of HIV infection

When was the last time you asked a patient one of the following questions:

- "Are you sexually active?"
- "Are you sexually active with men, women, or both?"
- "How many partners did you have over the last 2 years?"

Since many physicians find it difficult to quiz their patients about sexual activities, assessing a patient's sexual activity risks will be one of the topics covered during a Texas Medical Association-sponsored conference, HIV Management: A Clinical Update. The Friday, October 30, conference will be held at TMA headquarters in Austin.

"There has been a real reluctance by physicians even before the emergence of HIV to conduct sexual and drug histories," says Deborah Brimlow, PhD, assistant professor at The University of Texas School of Public Health. Dr Brimlow, who will present the conference session on sexual history taking, says the major information barrier is that physicians and other health-care providers just don't ask the basic questions. "Physicians are human, too," she said. "And they tend to have their own difficulties with sexuality along with their patients' sexuality. The questions concerning HIV infection and AIDS are even more sensitive."

Other topics and speakers at the conference will include:

- Epidemiology of HIV/AIDS: Richard Grimes, PhD, director of the AIDS Regional Education and Training Centers.
- Medical management of HIV Disease: Robert Awe, MD, associate professor, Baylor College of Medicine.
- Women and HIV disease: Hunter Hammill, MD, assistant professor, Baylor College of Medicine.
- Pediatric aspects of HIV disease: Mark Kline, MD, assistant professor, Baylor College of Medicine.
- Access to clinical trials: Richard Pollard, MD, professor of internal medicine and microbiology, The University of Texas Medical Branch at Galveston.

Other topics will include neuropsychiatric aspects of HIV and legal issues.

Registration fee for the all-day conference is $125 and additional information is available from TMA at (800) 880-1300, ext 1461, or (512) 370-1461.

COMMENTARY

Screening mammography: our best chance to change the stats

George N. Peters, MD
President, American Cancer Society, Texas Division
Department of Surgery and Surgical Oncology
Sammons Cancer Center
Baylor University Medical Center

Breast cancer is still on the rise in Texas and in the United States, but we, as physicians, have a powerful opportunity to help reverse the trend.

As in previous years, the American Cancer Society is anticipating an increase in both the number of breast cancers diagnosed and in the deaths from breast cancer in 1992. In the United States, 180,000 new breast cancers will be diagnosed; 8,700 of those new cases will be in Texas. Nationwide, 46,000 women will die of breast cancer and approximately 2,200 of these deaths will be in Texas.

By the turn of the century, 1.5 million new cases of breast cancer will be diagnosed and approximately 500,000 women will die from this disease. This will be 10 times the number of men who lost their lives in the Vietnam conflict; it also will be more than the estimated deaths from the AIDS epidemic in the United States.

We, as physicians, do have a tool that will allow us to decrease the mortality from this disease. Yet, this modality is underutilized and we have to take partial responsibility for that. If we all practiced universal mammographic screening, we could decrease the mortality from breast

cancer by 30%.

The American Cancer Society has for years attempted to educate the public and physicians to the benefits of mammography. The Breast Cancer Detection and Demonstration Project has demonstrated that mammography alone can detect up to 41% of cancers in all women. In the age group of 40 through 49, 35% of the cancers were detected by mammography alone. Approximately 32% of these cancers were less than 1 cm and 80% of these cancers had negative axillary lymph nodes. Recent studies by Dr Peter Paul Rosen from Memorial Sloan Kettering have shown 20-year survival rates of up to 85% in cancers that are less than 1 cm and node negative.

Younger, educated, middle- and upper-income women are getting the message about mammography. Their compliance with American Cancer Society mammography guidelines is 41%. Unfortunately, the use of mammography by black women appears not to have increased, and only 11% of low-income Hispanic women over the age of 50 follow the guidelines. In Texas, only 29% of women 50 years and older who saw a physician for routine examination had a screening mammogram in the last year. We must improve this statistic.

In 1987 and 1988, the American Cancer Society, Texas Division, conducted a statewide screening program offering $50 mammograms through a comprehensive television campaign. More than 100,000 women responded and underwent screening mammography. The American Cancer Society is committed to a yearly campaign to increase the utilization of mammography until we have *universal* mammographic screening in Texas by the turn of the century.

IF WE ALL PRACTICED UNIVERSAL MAMMOGRAPHIC SCREENING, WE COULD DECREASE THE MORTALITY FROM BREAST CANCER BY 30%.

It is essential that we have the support of all Texas physicians. During the screening projects of 1987 and 1988, 62% of those patients eligible to be screened stated that they relied on regular doctor visits for their breast examinations, but their doctors had never recommended mammography. Approximately 50% of the patients stated that they would have mammograms if their physicians recommended them.

A recent National Cancer Institute study again confirmed that mammography is greatly underutilized. Mammography is significantly less utilized by women 65 years and older compared to younger women. This is indeed a striking statistic since breast cancer incidence rises sharply with age. The older segment of our population is now the fastest growing part of our society. By the year 2010, it is estimated that 15% of the population will be older than 65 years. It is therefore essential that we screen this population of older women. Breast cancer in older women is already at epidemic proportions and will be an overwhelming national health problem by the year 2010.

If we are to achieve universal screening, we must have the cooperation of Texas physicians. A national survey conducted by the American Cancer Society in 1989 showed that only 37% of physicians interviewed followed the American Cancer Society recommendations for screening mammography in asymptomatic women. Although this had significantly increased since 1984 when only 11% of surveyed physicians followed the guidelines, we still need to convince more physicians of the benefits of mammography.

Predominant reasons given by physicians in 1989 for disagreeing with the American Cancer Society guidelines were primarily related to the recommendation for baseline mammogram and the belief that annual testing after 50 years of age was too frequent. Costs were cited by 18% of physicians as a basis for disagreeing with the guidelines. Further, 16% of the physicians felt mammography was not needed in asymptomatic patients and 12% thought it unnecessary in the absence of a family history.

The American Cancer Society has recently changed its recommendations stating that a baseline mammogram should be done by age 40. As stated previously, in women 40 years and older, the benefits of mammography do begin to manifest themselves in statistical analysis. Since more than 75% of breast cancers are diagnosed in women older than 50 years, and since breast cancer is a disease of older women, it would appear effective to recommend annual testing in women more than 50 years old. Radiologists throughout the state are attempting to lower the expense of mammography through cost-effective means and through the use of mobile units.

It is time that we start seeing a

decrease in the mortality from breast cancer. Every physician in Texas has the potential to help the American Cancer Society and other organizations in the state achieve this goal. Through the cooperation of Texas physicians, we can achieve universal screening. Today, in 1992, I still see advanced breast cancers in women who should have had yearly screening mammograms, yet never had this life-saving procedure.

Please come on board and help us achieve our goal. Our patients *do* listen to us and *do* follow our recommendations.

Directory lists medication programs for indigent patients

A DIRECTORY THAT LISTS 59 corporate programs offering prescription drugs to indigent patients is being distributed by the Pharmaceutical Manufacturers Association to physicians across the country. A toll-free hotline number is available for physicians who have questions about the program, but the directory must be ordered in writing from 1992 Directory of Prescription Drug Indigent Programs, PMA, 1100 15th St NW, Washington, DC 20005. The hotline number is (800) 762-4636 (PMA-INFO).

For information about cardiovascular drugs available to the medically indigent, see p 62.

CDC LISTS RECOMMENDATIONS FOR FOLIC ACID SUPPLEMENTATION

PHYSICIANS NEED TO KNOW about the Centers for Disease Control's recommendation for folic acid supplementation, say the Texas Medical Association Committee on Maternal and Child Health and the TMA House of Delegates.

The following recommendations for women who have had an infant or fetus with spina bifida, anencephaly, and encephalocele appeared in the August 2, 1991, issue of *Morbidity and Mortality Weekly Report:*

- Women who have had a pregnancy resulting in an infant or fetus with a neural tube defect should be counseled about the increased risk in subsequent pregnancies and should be advised that folic acid supplementation may substantially reduce the risk for neural tube defects in subsequent pregnancies.
- Women who have had a pregnancy resulting in an infant or fetus with a neural tube defect should be advised to consult their physician as soon as they plan a pregnancy. Unless contraindicated, they should be advised to take 4 mg per day of folic acid starting at the time they plan to become pregnant. Women should take the supplement from at least 4 weeks before conception through the first three months of pregnancy.
- The 4 mg daily dose should be taken only under a physician's supervision. Tablets containing 1 mg of folic acid are available as a prescription item. The folic acid dose should be obtained from pills containing only folic acid. Multivitamin (over-the-counter and prescription) preparations containing folic acid should not be used to attain the 4 mg dose because harmful levels of vitamins A and D could also be taken. Prescribing physicians should be aware of the potential for high doses of folic acid to complicate the diagnosis of vitamin B12 deficiency. Anemia resulting from vitamin B12 deficiency may be prevented with high doses of folic acid; however, the neurologic damage that can result from vitamin B12 deficiency could continue.
- These recommendations are provided only for women who have previously given birth to an infant or had a fetus with a neural tube defect; they are not intended for 1) women who have never given birth to an infant or had a fetus with a neural tube defect, 2) relatives of women who have had an infant or fetus with a neural tube defect, 3) women who themselves have spina bifida, or 4) women who take the anticonvulsant valporic acid — a known cause of spina bifida.

Drug companies offer cardiovascular drugs to medically indigent

RECENTLY, AN AMERICAN Heart Association Task Force met to investigate the problems of access to health care in the United States, particularly drugs for the medically indigent. The task force found that many pharmaceutical companies offered drugs to the indigent at little or no cost. Following is a list of the companies, the cardiovascular drugs available, how these drugs can be obtained, and eligibility requirements. This list is not all inclusive. The information is reprinted by permission of the American Heart Association, Inc, and originally appeared in the May/June 1992 issue of *Heart Disease and Stroke, A Journal for Primary Care Physicians*, Vol 1, No. 3, pp 155–157.

Company and Cardiovascular Products	Who is Eligible/How Products Are Obtained
Bristol-Myers Squibb All 17 cardiovascular products, such as Capozide Capoten Betapen	Patients obtain an 800 number from their physician and call the reimbursement counselor to determine if they are eligible. If a patient is ineligible for Medicaid or other third-party reimbursement programs but in need of assistance, the counselor will send an application to the patient's physician. The physician and patient complete and sign the form, attach a prescription, and return the form to the counselor. After eligibility is determined, a 90-day supply will be sent to the patient's physician. A counselor will follow up each case. When the 90-day supply is nearly depleted, the physician will receive a letter asking for certification that the patient's financial status has not changed and that the patient needs the drug for another 90 days. After 180 days, the patient must requalify. Contact: 1-800-736-0003.
CIBA-GEIGY All cardiovascular products	Available to outpatients who are ineligible for third-party reimbursement for prescription drugs and deemed indigent by their physician. An application that contains the physician's signature, DEA number, and a prescription for a 3-month supply of the product is submitted by the physician. The drug supply is sent by United Parcel Service to the physician for dispensing to the patient. A completed application and prescription are required for each 3-month supply. Contact: 908-277-5849.
G.D. Searle & Company Eight cardiovascular drugs, including Calan Kerlone Nitrodisc	Drugs are provided free to anyone who is uninsured. Requests are made by the patient's physician. The patient is given a certificate that can be redeemed at any pharmacy. Searle reimburses the pharmacist through the company's "Patients in Need Program." Contact: 1-800-542-2526.
Genentech Activase	A patient must have an annual family gross income of less than $25,000. Patients cannot be eligible for or receiving Medicaid, Medicare, county or state assistance programs, or have private insurance coverage. The hospital completes a qualification form and provides documentation to verify the patient's annual family gross income, the diagnosis, and dosage of Activase. Replacement vials are shipped to the hospital pharmacy within 30 days of receipt of all required documentation. Contact: 1-800-879-4747.
Glaxo Trandate	Exclusively for private outpatients who are considered medically indigent by the physician and who are ineligible for any other third-party drug reimbursement program. Additionally, for a patient to be considered indigent and eligible for this program, the physician must waive fees for the patient. The physician must complete an application requiring the physician's signature and DEA number. Contact: 1-800-GLAXO77.

Company and Cardiovascular Products	Who is Eligible/How Products Are Obtained
Hoechst-Roussel Pharmaceuticals Lasix Altace	Case-by-case basis. This policy covers patients who are ineligible for Medicaid or other third-party reimbursement. Upon receipt of the physician's prescription and a letter certifying that the patient is medically indigent, Hoechst-Roussel provides the product without charge to a pharmacy for dispensing to the patient. Contact: 1-800-445-4774.
ICI Pharmaceuticals Group Tenormin Zestril	Requests are made through an application process that involves both the physician and the patient. Contact: 302-886-2231.
Knoll Pharmaceuticals Isoptin Rythmol	Knoll distributes medication to the medically indigent in three ways: 1) free samples are given to physicians, who pass them along to patients; 2) physicians request a package of free medication from Knoll by completing a form or writing a prescription (prescription drugs take 3–4 weeks; Knoll limits each physician's request to two per month); and 3) patients obtain a certificate from their physician and take it to a pharmacist to receive 30 free tablets. Contact: 1-800-524-2474.
Lederle Laboratories Maxzide ProStep Verelan	Case-by-case basis. Program involves the pharmaceutical representative, the physician, and the patient. The physician completes and signs a form declaring the patient medically indigent. The patient is then entered into Lederle's "Patient Assistance Program." Contact: 1-800-533-3753.
3M Pharmaceuticals Tambocor Minitran	Case-by-case basis. A confirmation of need from the physician or social worker is required. Contact: 1-800-328-0255.
Marion Merrell Dow All cardiovascular prescription products	Case-by-case basis. The physician makes a request to the company. A program description is then sent to the physician. The physician completes the paperwork regarding the medically indigent patient and returns it to Marion Merrell Dow. The drug is then sent to the physician for the patient. Marion Merrell Dow is in the process of enhancing its program. Contact: 816-966-4000.
McNeil Pharmaceuticals Vascor	Case-by-case basis. Program requires a signed and dated prescription that includes the physician's professional designation, the state license or federal DEA number, and a brief statement affirming that the patient is medically indigent. The product is sent to the physician. Contact (call collect): 215-628-5297.
Merck Sharp & Dohme All cardiovascular drugs except injectable medicines	Physician sends a written request with a brief statement of the patient's medical need, financial hardship, and absence of insurance eligibility. A signed and dated prescription with professional designation and state license or DEA number must be included. The physician's prescription determines the amount of medicine, not to exceed a 3-month supply, which is shipped to the physician. Contact: 215-540-8600.
Miles Inc Pharmaceutical Division Adalat Nimotop	The patient must complete an application form and certify that the information is correct. Once the application is approved, the product is sent to the physician. Contact: Kevin Higgins, MD, 1-800-468-0894.

Company and Cardiovascular Products	Who is Eligible/How Products Are Obtained
Pfizer All Pfizer cardiovascular drugs, including Cardura Procardia Procardia XL	Under the "Pfizer Indigent Program," physicians providing uncompensated care to medically indigent patients can write to the company advising them that the patient's prescription is not being reimbursed by Medicaid or a third-party insurance program. The company will then supply the medication to the physician at no charge, provided a prescription for the product is enclosed. Contact: 212-573-3954.
Roche Laboratories, Division of Hoffman-La Roche Inc; Roche Products Inc All cardiovascular drugs, including Bumex Valium	Available to outpatients who are ineligible for a third-party reimbursement program. Inpatients and those who can obtain drug reimbursement from other sources are ineligible. An application must be completed with the physician's signature and DEA number. The company will ship up to a 3-month supply to the physician; delivery usually takes 2–3 weeks. A repeat request does not require a full application, only the patient's initials or chart number, the drug, and dosage. Contact: 1-800-526-6367.
Sandoz Pharmaceuticals Sandimmune	Administered by the National Organization for Rare Disorders (NORD), the "NORD/Sandoz Drug Cost Share Program" is a source for patients whose federal, state, or private insurance funds and other resources do not cover the costs for the identified products. Generally, patients or guardians submit their own application to NORD. Eligibility is determined by medical and financial criteria and applied to a cost-share formula. Contact: 1-800-447-NORD.
SmithKline Beecham Dyazide	Case-by-case basis. For the "Indigent Patient Program," a physician contacts a sales representative, who delivers the product (up to a 3-month supply) to the physician. Patients are not required to submit any forms to be enrolled in this program; however, the physician should send a letter confirming patient need and eligibility. Contact: 215-751-5760.
Eminase	To be eligible for the "Compassionate Care Program," the patient must demonstrate that he or she does not have insurance. Single patients must have an income of $18,000 or less; married patients or patients with at least one dependent must have an income of $25,000 or less. The hospital should submit a hospital consent form, an application form, and a copy of the patient's clinical record. The drug will be shipped to the hospital within 30 days after the application has been approved. Contact: 1-800-866-6273.
Wyeth-Ayerst Various cardiovascular drugs	Case-by-case basis. This program requires a signed and dated prescription that includes the physician's professional designation, the state license or federal DEA number, and a brief statement affirming that the patient is medically indigent and has no form of coverage for pharmaceutical products. The product is sent to the physician. Contact: 215-971-5604.

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

Prevalence of human immunodeficiency virus infection in hospitalized adults at a teaching hospital in West Texas

THOMAS BUTLER, MD
JOHN SAWYER, PHD

The prevalence of infection with human immunodeficiency virus (HIV) among hospitalized adults at a teaching hospital in West Texas was estimated by conducting a serological survey. Of the 2,458 patients tested, 12 (0.5%) were seropositive. All 12 were men of ages 28 through 50 years; 11 were white and 1 was Hispanic. Eleven were previously known to be HIV positive and were hospitalized for illnesses related to acquired immunodeficiency syndrome (AIDS). All seropositive patients were hospitalized on nonsurgical services of internal medicine, medical-surgical neurology, and family practice. These results indicated that the sampled population in West Texas showed a relatively low prevalence of HIV infection and that seropositive patients were predominantly white men hospitalized for AIDS-related illnesses.

Dr Butler, Department of Internal Medicine; Dr Sawyer, Department of Pathology, Texas Tech University Health Sciences Center, Lubbock, Tex. Send reprint requests to Dr Butler, Department of Internal Medicine, Texas Tech University Health Sciences Center, Lubbock, TX 79430.

IN A SURVEY OF SENTINEL hospitals in the United States, the seroprevalence of infection with human immunodeficiency virus (HIV) showed a range of positives from 0.1% to 7.8%, with highest rates in the northeastern states and lowest rates in the western states (1). Blacks and Hispanics carry a disproportionate burden of infection with HIV as a result of the increased use of intravenous drugs in these racial groups that is most evident in eastern urban areas (2). Groups in which ages ranged from 25 through 45 years show higher prevalences of infection with HIV than younger and older groups (1,3). Lubbock is a city in West Texas with a population of about 180,000. The city serves surrounding rural communities that are engaged predominantly in farming and the oil industry. West Texas has been considered a low endemic area for infection with HIV. The following survey was undertaken in adult inpatients at a teaching hospital in Lubbock to define seroprevalence of infection, and, for purposes of infection control, to identify, if present, high-risk persons by age, gender, and hospital service.

PATIENTS AND METHODS

Sampling

Between October 1988 and November 1989, we obtained 2,458 samples of sera from leftover samples that had been taken the previous day from hospitalized adults at University Medical Center, Lubbock, Tex, for chemical or serological measurements. For a serum to be collected, at least 0.5 ml of serum had to be left over; the patient had to be still in the hospital available to approach for consent, had to be an adult of 18 years old or older (on obstetrics 16 years or older), and must not have been previously included in the survey. Sera were collected without regard for diagnosis or presence of risk factors for exposure to HIV. On any given workday, we tried to collect 15 sera, choosing the first tubes available in test tube racks to reach each day's goal.

Consent

Patients whose sera were collected were approached for written informed consent with conditions that the testing was part of a survey, that the results would be confidential and not entered into the medical chart, and that no charges would be made. Pretest counseling was provided. Patients were given a choice to be notified of the results of testing by phone or by letter or to not be notified. All patients consented. In several cases, we approached families of postoperative or comatose patients and telephoned or corresponded with others to obtain consent.

Serological testing

All sera were initially screened by the enzyme-linked immunosorbent assay (ELISA) test for HIV antibodies (Abbott HIV EIA, Abbott Laboratories, North Chicago, Ill). Sera that tested positive were retested in duplicate. If 2 or more of the 3 test results were positive, the specimen was considered ELISA positive and sent for confirmatory western blot testing at DuPont Co (Wilmington, Del). The criterion for positive western blot was presence of antibodies against gp160, gp120, and gp41. Sera were also tested against a recombinant ELISA for Env9.

Statistical testing

Data were subjected to log-linear analysis and Fisher's exact test for association (4).

Table 1. Prevalence of HIV positivity by age group.

Years of Age Group	No. Positive/No. Tested (n=2,458)	% Positive
16–29	3/863	0.3
30–39	6/393	1.5
40–49	2/314	0.6
50–59	1/290	0.3
60–69	0/302	0
70–79	0/194	0
≥80	0/102	0

Table 2. Prevalence of HIV positivity by gender and race.

Gender or Race	No. Positive/No. Tested (n=2,458)	% Positive
Male	12/999	1.2
Female	0/1459	0
White	11/1243	0.9
Black	0/317	0
Hispanic	1/898	0.1
White male	11/549	2.0
Black male	0/123	0
Hispanic male	1/327	0.3

Table 3. Prevalence of HIV positivity by hospital service.

Service	No. Positive/No. Tested	% Positive
Internal Medicine	8/807	1.0
Obstetrics/Gynecology	0/643	0
Surgery	0/512	0
Orthopedics	0/178	0
Medical-surgical neurology	2/154	1.3
Family practice	2/87	2.3
Anesthesia	0/36	0
Ophthalmology	0/34	0

RESULTS

Serological results

When sera of 2,458 patients were subjected to the ELISA test for HIV antibodies, 16 sera yielded repeatedly positive results. When these 16 sera were tested in western blot, 12 were positive for specific antibodies against HIV antigens gp160, gp120, and gp41. Furthermore, antibodies against antigens p24 and p66 were present in 10 of these 12 sera, against p51 and p31 in 8, and against p17 in 6. The 12 sera that tested positive in western blot against gp160, gp120, and gp41 also tested positive with recombinant ELISA with Env9.

Prevalence of HIV positivity by gender, age, and race and hospital service

The overall prevalence of HIV positivity was 12/2458, or 0.5%. All positives occurred in men, whose ages ranged from 28 through 50 years, with a median of 35 years. The age decade from 30 through 39 years showed the highest prevalence, 1.5% (Table 1).

The races of the 12 positive cases were white in 11 patients and Latin American in 1 patient (Table 2). When men only were considered, whites showed a prevalence of positivity of 2%. The 12 positive cases were hospitalized on services of internal medicine (8 cases), family practice (2 cases), and medical-surgical neurology (2 cases). No positive cases were detected from sera collected from a total of 1,333 patients on obstetrics/gynecology, surgery, orthopedics, anesthesia, and ophthalmology services (Table 3). Eleven of the 12 HIV-positive cases were known to have tested positive before, whereas testing of the remaining patient had yielded an inconclusive result.

Statistical correlations

The presence of 643 females from obstetrics/gynecology led to a weighting of the sample toward women in the age groups of 16 through 39 years. Patients older than 49 years were at low risk of becoming infected with HIV, with only one patient older than that, 50 years old, being seropositive. We excluded patients from obstetrics/gynecology and those older than 49 years from the following analyses of associations with HIV positivity. This exclusion was consistent with log-linear analysis of the data, which showed little association between the factors of gender, age, race, and service in the remaining patients. Thus, all the remaining patients could be used in the construction of 2 x 2 tables for exact tests of association between HIV positivity and any one of the designated factors, without the other factors influencing the test as confounding variables. By gender, males were significantly more likely to be HIV positive than females (P=.003 by Fisher's exact test). By race, white persons were significantly more likely to be HIV positive than nonwhite (P=.012 by Fisher's exact test). By hospital ser-

vices, nonsurgical services (internal medicine, medical-surgical neurology, and family practice) were significantly more likely to have HIV-positive cases than the surgical services (surgery, orthopedics, anesthesia, and ophthalmology, P=.001 by Fisher's exact test).

DISCUSSION

Showing a seroprevalence of HIV infection of 0.5% in unselected adult inpatients at our teaching hospital in West Texas, these results indicate that a significant proportion of our patients harbor this infection. Compared to national trends, this is a relatively low endemic region as we would expect from previous surveillance data (1). While our method of sampling could underestimate the prevalence of HIV infection by missing some cases, we think it is unlikely because our sample approximated a randomly chosen cross section during a year's period and because all patients approached for the survey gave consent. Actually, our seroprevalence would have been much lower had we excluded patients with known or suspected acquired immunodeficiency syndrome (AIDS), as was done in the survey of sentinel hospitals (1). Since 11 of our patients who tested positive had been previously diagnosed, only 1 patient was detected for the first time; thus, our prevalence among patients without any suspicion of a diagnosis of infection with HIV was only 0.04%, placing us at the very low end of the national data from sentinel hospitals. In New Mexico, another low endemic area for infection with HIV, patients attending sexually transmitted disease clinics showed a seroprevalence rate of 1.6% (5), indicating that selected groups in low endemic areas are transmitting this infection.

The extent to which our hospital-based seroprevalence of infection with HIV reflects that of the surrounding community can only be surmised. However, the community at large is likely to have a much lower rate of infection because children, who are at low risk for HIV infection, were excluded and because patients hospitalized with known or suspected AIDS were included in our sample, giving our sample a bias due to illness.

Our finding of seropositivity only in men is in keeping with the national trend of strong male preponderance in HIV infection. The total absence of seropositive females was something of a surprise because our sample contained 1,459 females, of whom 643 were on the obstetrics/gynecology service. A serosurvey in New York revealed that 2% of women delivering children were seropositive for infection with HIV (6). A reason for the absence of infection in females may be that intravenous drug use is infrequent among females in this region.

All except one of our seropositive cases were white; the one exception was Hispanic, and there were no blacks. This higher prevalence among whites than among blacks and Hispanics is exceptional for national trends (7) and was observed in only one of the sentinel hospitals, located in a western state (1). Our low prevalence among minority races can be explained by the small number of black males in our survey and by our Hispanic population being comprised mostly of Mexican Americans, who in this region apparently practice intravenous drug use much less frequently than Puerto Rican Hispanics in northeastern cities.

The location of seropositive patients on nonsurgical services of internal medicine, medical-surgical neurology, and family practice occurred because these patients were hospitalized for treatment of illnesses related to AIDS. On the other hand, health-care personnel at our facility who express the most concern about dangers of HIV transmission in the hospital are surgical staff in the operating rooms. Our results indicate that our patient population shows a relatively low frequency of infection with HIV and that white men in the age range of 30 through 50 years on nonsurgical services show the highest rates of infection. Despite the low frequency of infection with HIV shown in this serosurvey, which contrasts with rates of seropositivity higher than 5% among patients treated in emergency rooms in northeastern cities (8), our staff prudently follow universal precautions to avoid contact with blood and bodily fluids of any unsuspected patients who may be infected.

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Risk factors for infection with human immunodeficiency virus among low-income women undergoing voluntary sterilization

Alfred N. Poindexter, MD
Margaret L. Frank, PhD
Gabriela Villarreal, MD, MPH
Michael L. Johnson

Data regarding risk for infection with human immunodeficiency virus (HIV) were collected from 486 women who presented in 1989 for tubal sterilization through a clinic operated by a medical school. This clinic was participating in a blind surveillance project administered by the local health department. The project was designed to estimate the prevalence of seropositivity for HIV among women seeking family planning services within the department's catchment area. The expectation was that the population of women choosing voluntary sterilization would be of relatively low risk for HIV infection. Surprisingly, however, when they were examined, nearly 25% of these women reported at least one identified risk factor for HIV infection. The rates for certain specific risk factors are no lower among these women than among the general population.

From The Baylor Population Program, Department of Obstetrics and Gynecology, Baylor College of Medicine, One Baylor Plaza, Houston, Tex. Send reprint requests to Dr Poindexter, Baylor College of Medicine, One Baylor Plaza, Texas Medical Center, Houston, TX 77030.

The number of persons with acquired immunodeficiency syndrome (AIDS) is expected to increase in this decade, with the number of reported cases diagnosed in the United States in the first 11 months of 1990 exceeding 37,000 (1). The number of persons with AIDS is estimated to be only 10% of the total number of persons infected with human immunodeficiency virus (HIV), which causes the infection that produces the disease (2). As the prevalence of AIDS is expected to increase, so the associated deaths and prevalence of HIV can be expected to climb. The occurrence of AIDS in women in the United States has been described as an "evolving epidemic" (3). The numbers of AIDS cases in women have been increasing consistently, including more than 15,000 women in this country in 1990 (4). In the year preceding November 1, 1990, there were 4.3 AIDS cases reported per 100,000 women. Eighty-five percent of those cases occurred in women of childbearing age (15 through 44 years) (5).

Infection with HIV is spread primarily through three modes of transmission: sexual contact, perinatal transmission, and exposure to infected blood. Women may be at risk for infection through transmission by sexual contact and by use of intravenous drugs. Most women with AIDS acquired the disease by sharing needles (6,7). Infected women may further infect others through sexual contact or intravenous-drug use, and pregnant women who are seropositive for HIV are likely to infect their unborn children. Thus, an investigation into the risk for HIV among women of childbearing age is necessary.

Nationally, the proportion of women with AIDS has increased since 1982 (5). The Metropolitan Statistical Area that includes Houston, Tex, currently numbers fourth in the nation for cases of AIDS (8). While only 4% of persons diagnosed with AIDS are female, the proportion can be expected to increase if this disease follows national patterns. A greater prevalence of infection with HIV associated with heterosexual transmission and intravenous-drug use is likely to lead to an increased incidence of the disease among women. Heterosexual transmission accounts for more than 28% of AIDS cases in women (9).

Most published data detailing risk factors for transmission of HIV have been based on self-reports from individuals who test positive for HIV or from current patients with AIDS. Only a few sources have reported the prevalence of risk factors in the general population, and these reports contain little detail describing risk behaviors in women.

Although they would not be bearing children in the future, the women attending a family planning clinic for tubal sterilization in the Houston area presented an opportunity for our research team to explore the level of risk for HIV within a female population expected to be at relatively low risk for the infection. We had originally assumed that this clinic population would exhibit a seroprevalence rate for HIV similar to that of the general population of women of reproductive age in Texas. Based on tests of blood samples from newborn infants, the prevalence of infection with HIV in the general population of childbearing women in Texas was reported to have been 0.9 per 1,000 in 1988 and 1.0 per 1,000 in 1990 (3,5). In 1989 and 1990, the population of patients at our clinic generated a rate twice

that high. We must recognize that this finding represents only a few cases. Therefore, rather than attempting to make generalizations regarding prevalence of infection, we investigated the levels of risk factors for HIV that might be found in such a population.

Women attending family planning clinics and choosing sterilization as their method of contraception are actively taking responsibility for their reproductive behavior. We might expect such a population to exhibit a lower incidence of certain HIV-related risk factors.

This assertion is based on two premises. First, a concern for responsible family planning can be expected to coincide with other future-oriented behavior. Women who have positive life plans are generally more highly motivated to participate in family-planning activities that use effective contraceptive methods (10). Second, other conduct that reflects a greater concern for maintaining good health, a necessity for a positive future, might be expected from this population. Most behavior associated with increased risk of infection with HIV — excluding birth location and transfusion — might imply a reduced regard for personal health.

MATERIALS AND METHODS

The Baylor College of Medicine operates a family planning clinic that serves the greater Houston area. Among other services, the clinic performs tubal sterilizations. Approximately 500 of these procedures are performed annually. The clinic participates in a blind surveillance project that is administered by the local health department. Blood samples from each patient are sent to a screening laboratory, accompanied only by the identifying information of the race and ethnicity of the patient, a checklist of certain risk exposures, and the clinic location. Prevalence rates are reported for the city as a whole and for specific sites.

From a sample of 468 women who presented for tubal sterilization in 1989 at this clinic, data were collected that detail their risk for infection with HIV. During the course of the initial history and examination, a series of questions were asked of each woman requesting tubal sterilization. Several questions addressed known risk factors associated with AIDS and precipitating infection with HIV. Those risk factors studied included history of intravenous-drug use, previous diagnosis of a sexually transmitted disease, prior blood transfusion, birth in a Pattern II country, and relations with a high-risk partner (defined by these same risk factors). [Patterns of infection with AIDS have been categorized by WHO and identified according to geographic areas. Pattern II describes Sub-Saharan Africa and the Caribbean, where transmission occurs primarily through heterosexual contact and blood transfusion and where rates of perinatal transmission are particularly high. Pattern I describes North America, Western Europe, Australia, New Zealand, and parts of Latin America. In these areas, transmission has been primarily among male homosexuals and intravenous-drug users. Areas with low rates of infection are described as pattern III.] In addition, certain demographic data were compiled. The rates of risk factors were described and compared with a second population as reported below.

RESULTS

Twenty-eight percent of the women in the study population were younger than 25 years when their operations were performed. Sixty-three percent were younger than 30 years. Only 4% (19 subjects) were older than 40 years.

Forty-three percent of the women identified themselves as Hispanic. Thirty percent were black, and the remaining 27% were white, with less than 1% indicating another racial or ethnic group, or failing to indicate a category. All but 11 subjects resided in the same county in which the clinic was located. The religious preferences indicated by the majority of women were Catholic (38%) and Baptist or Methodist (36%).

Fifty-seven percent of the subjects were married, the definition of which included common-law arrangements.

Table 1. Primary method of contraception prior to surgery.

Method	Frequency	Proportion of Sample
Oral contraceptive	181	0.39
Abstinence	59	0.13
Condoms, foam, or both	109	0.23
Postpartum	20	0.04
None	50	0.10
Other	37	0.08
No response	12	0.03
Total	468	1.00

Table 2. Reported risk factors for infection with HIV.

Risk Factors for Infection with HIV	Frequency	Proportion of Subjects with at Least One Risk Factor*	Proportion of Total Subject Group
History of intravenous drug use	7	0.060	0.015
Blood transfusion	25	0.216	0.053
Pattern II country	1	0.009	0.002
Previous sexually transmitted disease	71†	0.612	0.152
High-risk partner	32	0.276	0.068

* Twenty subjects reported two risk factors; therefore, this column total exceeds 100%.

† Two subjects had been diagnosed with two prior sexually transmitted diseases; therefore, the number of cases of diseases totals 73, while only 71 subjects had this risk factor.

The unmarried remainder included women who were separated, divorced, widowed, or never married. More than one half of the subjects (53%) had not finished high school. No subjects were younger than 18 years at the time these data were collected; therefore, age was not a factor limiting the number of years of schooling available to these women.

Reported annual income was relatively low. While 19% of subjects failed to report their levels of income, of those who did disclose income, more than 75% reported an annual household income lower than $10,000. Less than 3% of the subjects indicated an income greater than $20,000 per year.

The women each had an average of 2.7 children. Only 4% of the women studied had had no previous live births before the surgery. Twenty-seven percent had four or more children.

The women reported that their primary method of contraception prior to surgery was oral contraceptives, used by 39% of the subjects. Eleven percent reported using no method, and 3% failed to answer the question. Table 1 shows the primary method of family planning used by each subject during the 3 months prior to her surgery.

Of the population studied, 116 women (24.8%) reported at least one known risk factor for infection with HIV. Table 2 indicates the frequency with which each risk factor was reported. Note that 20 subjects indicated two risk factors. Thus, the total frequency in Table 2 is 136 rather than 116.

Seventy-one subjects had previously experienced a sexually transmitted disease. This represents 61% of those subjects with at least one risk factor and 15% of the total study population. Of these 71 subjects, 35% (25 subjects) had gonorrhea, 21% (15 subjects) had syphilis, and 21% (15 subjects) had chlamydia. Nine women, 12% of those with prior STDs, suffered from herpes.

DISCUSSION

The population studied was relatively young for selection of surgical sterilization as a contraceptive method. For women of childbearing age, as age increases the use of sterilization generally increases. Few women under 25 years choose surgical sterilization as their method of contraception, while nearly 26% of women between the ages of 35 and 39 opt for sterilization (11).

The low level of income reported is not surprising considering the nature of the clinic, which caters to lower-income women. A higher distribution of income was not expected from a sample drawn from this site.

The women studied had considerably more children than the average population, given a total national fertility rate of 1.8 per woman (9). Such high birth rates are expected, however, among populations with high proportions of persons of Hispanic origin and among women electing tubal sterilization (12,13).

The results regarding previous contraceptive practices may be compared with those of the general population of women of comparable age. We might expect as many as 13% to report using no method and as few as 22% to use oral contraceptives as their method of birth control (9). Within this study group, only 11% reported using no method and 39% reported using oral contraceptives. Not surprisingly, this population is slightly more actively involved in family planning, which may suggest a group of women who are more concerned with these issues than the average population. A greater level of concern would be expected from a group electing sterilization as their method of family planning.

The subjects' choice of steriliza-

tion as their future contraceptive method raises an additional question. Prior to surgery, 23% of the subjects reported using condoms and/or spermicide for contraception. These methods are known to reduce the risk of HIV transmission (14–16). However, after being sterilized, some of these women may be less likely to use such methods because they are no longer necessary to prevent pregnancy. This behavior may further increase their risk for HIV. In addition, participation in unprotected intercourse by high-risk women can increase risk of transmission to others.

The characteristically low-income level of this sample, in relation to the population at large, should be noted. Low-income populations are often represented disproportionately among those infected with HIV (17,18). Risk-factor data for samples of women at higher levels of income have not yet been published. Thus, differences associated with income are not available. The prevalence of infection diagnosed among women at all income levels has been lower than that for men in this country. When we compare this sample to others containing both men and women, we expect the levels of HIV-related risk factors to be lower for an all-female population.

A California study that examined a sample of the general population reported similar levels of certain risk factors to those found in this investigation (19). The California sample, however, included both heterosexual and homosexual males. We would expect a sample of women to experience a considerably lower risk of infection with HIV, but this was not the case for this sample. More than 24% of the subjects in our sample reported at least one known risk factor for HIV infection. Of a sample of women presenting voluntarily for HIV testing and counseling, only 20% reported known risk factors (4). When the primary modes of transmission through which this population becomes at risk for infection with HIV were examined, these women were at no lower risk than the general population. Of the total population we studied, 1.5% reported a history of intravenous-drug use. Women are presumed to experience a lower level of this risk factor. However, in the general population — including men and women — only a slightly higher level, approximately 1.7%, is estimated to have used intravenous drugs (12).

Our study population's rates for risk factors associated with blood transfusions and high-risk partners were also similar to those reported for a general population. The proportion having experienced a transfusion was 0.050 for the California sample compared with 0.053 for our study population. Levels of reported sex with a high-risk partner were identical (6.8%) for the all-female study group and for the mixed survey population.

In light of the increased community concern over sexual behavior and its impact on the transmission of HIV, the compilation of related behavioral information will help those professionals plan related intervention strategies (20). Given the level of risk for infection associated with this population undergoing, or simply investigating, sterilization as a contraceptive option, we should explore the potential for expanded health education intervention at sites providing sterilization services.

The effective treatment of individuals already infected with HIV is likely to be a long way off (21). Health professionals must, therefore, concentrate their energy in prevention. This requires attention to the behavioral elements that increase the risk of infection with HIV (22).

Twelve percent of women of childbearing age (15 through 44 years) choose sterilization as their method of contraception (14). Estimates of the proportion of women using contraception who choose surgical sterilization range from 20% to 25% (14,23). Approximately 650,000 to 700,000 women elect voluntary, surgical sterilization each year (24,25). They represent a sizable population, a large proportion of which may benefit from additional intervention targeting behavioral change. The potential to learn about and to provide intervention for this large and diversified population of women needs to be explored further.

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Classified Directory

OPPORTUNITIES AVAILABLE

Academics

The Child Section of the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma, College of Medicine, Oklahoma City, is recruiting child psychiatrists at the Assistant/Associate Professor level. The Child Section has a fully accredited Child Psychiatry Fellowship Program. Active research programs include child and adolescent depression, prevention of emotional disturbance, and child sexual abuse. Responsibilities of these positions include clinical service, as well as education and supervision of medical students, general psychiatry residents, and child fellows. Total compensation for these positions is very competitive and includes excellent fringe benefits. Tenure track is available. Applicants should be board-eligible or board-certified in child and adolescent psychiatry. Interested persons please contact Dr Ronald S. Krug, Chair of Child Search Committee, OUHSC, Department of Psychiatry and Behavioral Sciences, PO Box 26901, Oklahoma City, OK 73190. OUHSC is an AA/EOE.

The Department of Psychiatry and Behavioral Sciences at the University of Oklahoma, College of Medicine, Oklahoma City, is recruiting psychiatrists with interests in clinician/educator or clinician/researcher tracks. These positions can be at either the Assistant or Associate Professor level. Responsibilities of these positions include clinical service as well as education and supervision of medical students and general psychiatry residents. Total compensation for these positions is very competitive and includes excellent fringe benefits. Tenure track is available. Applicants should be board-eligible or board-certified. Interested persons please contact Dr Gordon Deckert, Interim Chairman, Department of Psychiatry and Behavioral Sciences, OUHSC, PO Box 26901, Oklahoma City, OK 73190. OUHSC is an AA/EOE.

The University of Texas at Austin Student Health Center is currently seeking a physician who is board-eligible or board-certified in family practice, internal medicine, or pediatrics. Experience in direct patient care and current license to practice medicine in the State of Texas is required. This position can be either a 9-month annual (September to May) or 12-month annual appointment. The Student Health Center has 16 other physicians and lab/x-ray and pharmacy facilities. You may call 512-471-4231 for more information. To apply, send a letter of interest and resume to: Nancy Van Vessem, MD, Interim Medical Director, The University of Texas at Austin, Student Health Center, Box 7339, University Station, Austin, TX 78713-7339. The University of Texas at Austin is an Equal Opportunity/Affirmative Action Employer.

Emergency Medicine

Needed: Emergency physicians — North Central Texas area, full and part-time. For an application call 817-336-8600 or write Emergency Medicine Consultants, PA, 1525 Merrimac Circle, Suite 107, Fort Worth, TX 76107.

San Angelo — Outstanding opportunity in minor emergency/family practice clinics. Guaranteed $100,000 for 4-day week, 13 hr days, 50 weeks/year. Profit sharing above guarantee. Contact Wayne Williams, MD, 915-942-8611, Shamrock Clinics, 4208 College Hills, San Angelo, TX 76904.

Dallas Area: Staff positions available for Emergency Physicians who are BC/BE in a primary care specialty or have equivalent emergency medicine experience. This Level II facility has an annual volume of approximately 14,000 and compensation begins at $100,000/year. For more information on this or other opportunities in Texas, contact Sterling Healthcare, Inc., at 1-800-999-3728, or send CV to 8700 Crownhill, Suite 600, San Antonio, TX 78209.

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Physician Resources Department
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P.O. Box 4448
Houston, Texas 77210-4448

In Houston call: (713) 446-9696
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Outstanding Emergency Medicine Opportunities — Sterling Healthcare, Inc., a progressive physician-oriented group committed to the highest standards in emergency medicine, has outstanding opportunities for qualified physicians. Compensation packages include a minimum hourly guarantee plus a percentage of collections, with paid $1M/$3M professional liability insurance included. Physicians also benefit by working in a flexible environment as independent contractors. To obtain more information, contact Sterling Healthcare, Inc., 8700 Crownhill, Suite 600, San Antonio, TX 78209 or call 1-800-999-3728.

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Endocrinology

Houston — Suburban location. Hospital-sponsored position. No other endocrinologist in the area. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911.

Family/General Practice

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McKenna Memorial Hospital
143 East Garza Street
New Braunfels, Texas 78130
1-512-625-9111, Ext. 194

Austin, Texas — Physician(s) needed for full time, part-time, weekdays, weekends to staff a free standing urgent care center. Remuneration commensurate with experience. Send CV and application to Austin Medicenter, c/o Sheila Twyman, Medical Administrator, 6343 Cameron Rd, Austin, TX 78723 or call 512-467-2052.

Family Practice — BE/BC family physician needed to join with 4 other family practitioners in a thriving practice in Beaumont, Texas. Modern, full-service clinic offers a guaranteed salary plus percentage of production and benefits. Send CV to Nancy Bloomfield, 4010 College, Suite 200, Beaumont, TX 77707.

FAMILY PRACTICE

Are you ready to enjoy rural life and a two-physician practice? The Atascosa RHI Health Clinic, Inc., a federally funded community health center, located at 310 W. Oaklawn, Pleasanton, Texas, 30 miles south of San Antonio, is the place for you. If interested, please call Jaime Garcia, MD, Medical Director, or Esther Maese, Executive Director, at 512-569-2527.

Family Practice — Long established and respected Houston multispecialty group is adding two family practice physicians. Excellent income and generous benefit package with partnership possibilities. Outstanding potential for professional growth. State-of-the-art facility soon to be constructed. For information, call Jerry Nisenson, 713-669-0344, 713-869-3701, or 1-800-944-4047.

1490 FP — Join two family physicians in a dynamic practice in a nice community in west central Texas. The successful candidate will want to practice the full range of medicine from pediatrics to geriatrics, including obstetrics. A new office equipped with the most modern equipment available, including x-ray, lab, ultrasound, Holter monitoring, and a minor surgical suite. A liberal compensation and benefit package is available. If you want to practice family medicine, this is the opportunity you should not overlook. For more information, call Fred Compton at 1-800-626-1857, ext 244.

Breckenridge Family Clinic P.A. is looking for a new associate immediately. Terms are negotiable. Prefer board-certified practitioner with dedication to and interest in rural medicine. Contact W.E. Prater, MD, at 817-559-7475 (Grad UTMB '84, John Peter Smith '87) or send CV to 103 S Hartford, Breckenridge, TX 76424.

Family Practice — Join a family group in San Angelo with multiple practice options: practice in a modern facility on a prestigious Air Force base; share emergency medicine coverage in the sponsoring hospital or practice in a private office setting. This unique practice is flexible and can lead to your own private practice either in solo or with associates. With a service area of over 120,000, there are ample activities for the entire family, an outstanding university, cultural events for everyone, and abundant outdoor activities. The compensation and benefit package is excellent. There are no administrative responsibilities and no risk. For more information, please call Fred Compton at Physician Services of America, toll-free at 1-800-626-1857, ext 244.

Scenic Colorado front range community of 30,000, with a strong, growing economic base, needs Family Physicians. Join a group of physicians or establish a solo practice with cross coverage. Full range of family medicine, including OB, available. Hospital offers generous guarantee for the physician wanting to be close to Rocky Mountain recreation as well as metropolitan areas. Call Rita Longino at 1-800-279-5267 or FAX CV to 1-800-467-1246, or send CV to WHS, PO Box 2107, Corrales, NM 87048-2107.

General Surgery

San Antonio — General/Vascular surgeon wanted for hospital staff position. Private practice and academic affiliation available. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911.

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Gold Mine for Internist — Wanted, aggressive and energetic physician, BE/BC to do consultations for a group of family physicians. Must be able to do procedures. Very competitive fee for service income available, including benefits. Salary is based on percentage of collections with a base salary guarantee. Send CV to Nancy Bloomfield, 4010 College St, Suite 200, Beaumont, TX 77707.

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OBGYN

OB/GYN — Long established and respected Houston multispecialty group is adding two OB/GYN physicians. Excellent income and generous benefit package with partnership possibilities. Outstanding potential for professional growth. State-of-the-art facility soon to be constructed. For information, call Jerry Nisenson, 713-669-0344, 713-869-3701, or 1-800-944-4047.

Country living with big city sophistication. We are looking for an associate to purchase a share of our practice in a small coastal town south of San Francisco, California. Reply with CV to Dr Stephanie Taylor, 880 Cass St, Suite 209, Monterey, CA 93940.

Ophthalmology

Austin — A two-office General Ophthalmology practice needs a General Ophthalmologist with interest in glaucoma. The position available is located in an office hospital complex with an additional day surgery facility. Both offices have adjacent optical shops. Contact Richard E. Nieman, MD, 512-452-8194.

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Primary Care Physicians comfortable seeing adult and pediatric patients to staff Houston-area community health centers. Full/part-time, no nights or weekends. Excellent benefits and malpractice. Baylor College of Medicine, an EEO/AA employer. Contact Granville Collins, 713-798-4491, Department of Community Medicine.

Primary Care, Huntsville — Hospital-Sponsored Rural Health Clinic. No nights, weekends, or call. Salary negotiable. Send CV or call Medical Staff Coordinator, Huntsville Memorial Hospital, PO Box 4001, Huntsville, TX 77342-4001; 409-291-4512.

Radiology

Expanding 15-Physician multispecialty group has excellent opportunity for a radiologist in friendly West Texas community of 25,000. Adjacent to a 153-bed modern hospital. Excellent guaranteed salary with no first year expenses in addition to benefits. Moving allowance also available. Direct inquiries or send CV to Gail Knous, Malone & Hogan Clinic, 1501 W 11th Place, Big Spring, TX 79720; 915-267-6361.

Diagnostic Radiologist with CT, MR, Interventional, US, Nuclear Medicine skills to join group of seven Board Certified Radiologists. Two hospitals, private offices, service to nearby communities. Centrally located to San Antonio, Austin, Houston, Corpus Christi. Good family environment. Contact James Neumann, MD, Box 3610, Victoria, TX 77903; 512-578-0317.

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FAX 713-784-9260
Reuben Bronstein & Associates

Position Available — Seeking BC/BE Family Practice, General Internist, Endocrinologist, OB/GYN to join established multispecialty clinic. Excellent benefits and guarantee. Send CV to Leroy W. Kitch, Administrator, Skinner Clinic, 124 Dallas St, San Antonio, TX 78205.

FP/PD/IM doctors needed for excellent fast-growing Houston suburb. Call Jerry Lewis, 1-800-666-1377.

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For lease just outside beautiful Hide-A-Way Lake. Medical office 2,000+ square feet, next to established pharmacy and across from two dentists. Hide-A-Way Lake, near Lindale, Texas, is a secured living area containing three lakes, an 18-hole golf course, lodge, etc, enjoyed by 3,600 residents, with an additional 3,600 people in the immediate area. Call 903-882-5081 days; 903-882-5019 nights.

For Sale or Lease — Stand-alone office for one or two physicians. Hospital district — Fort Worth. Owner taking missionary sabbatical. Call 817-336-4716.

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Internal Medicine, Solo Practice for sale in San Antonio. Net $200,000+ per year. Please write to PO Box 37610, San Antonio, TX 78237.

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continued on p 84

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H CENTRAL TEXAS
one hour of San Antonio - South Central Texas al seeks additional BE/BC family practitioner for e area of 20,000. OB is available, but not d. Hunting and fishing (fresh and salt water) and ecreational activities abound. Generous incentive ge to qualified candidate.
ct: Barry Strittmatter.

'H CENTRAL TEXAS
physicians needed. Practice with established y care group, or independently with shared call. 3. Interest in pediatrics a plus. Attractive, well-bed, 56-bed hospital. Competitive incentive ge. Contact: Jim Truitt.

'H CENTRAL TEXAS
r location, recreational paradise! Need two more offer full range of family medicine in town of); easy access to Dallas/Fort Worth. OB optional. nodern, 200-bed hospital. Excellent referral base ackup. Generous incentive package. This unity has it all! Contact: Vicki Truitt.

TEXAS
ncially sound, 48-bed hospital seeks board ed (or eligible pursuing certification) family lan to establish a solo practice. Call sharing and ge is available from other family physicians in the unity. This beautiful rural community is a tional mecca; hunting, fishing, water sports, ing, etc. Competitive incentive package to ed physician. Contact: Barry Strittmatter.

TEXAS
oard certified, recently trained family physicians eking additional family physician for associate e (or solo sharing call) in small university town one hour of D/FW Metroplex. No OB. Great life among sophisticated population without the es of, but access to, a large city. Lots of tional and social amenities. Generous incentive ge from community hospital to qualified doctor.
ct: Barry Strittmatter.

SO
ly respected and well-established physician in El (population approximately 500,000), wishes to He and the hospital with whom he is associated a board certified (or board eligible pursuing cation) family physician to join him and begin to e his large practice. Competitive benefit package lified candidate. Contact: Barry Strittmatter.

WORTH
physician needed to deliver basic primary care in rack" unit of busy ER. The regular hours of this n will allow you to enjoy a nice lifestyle in a city emendous amenities. Salaried position. Call us tails. Contact: Vicki Truitt

FORT WORTH
Largest family practice residency program in the country seeks division director to coordinate faculty development, (clinical) research and grant activities. Position encompasses teaching, patient care and administrative responsibilities. Prefer physician with rural practice experience; board certification required. Clinical assistant professorship appointment to major medical school; good income and benefits; little to no call. Join the team and enjoy your profession!
Contact: Vicki Truitt.

INTERNAL MEDICINE

NORTH CENTRAL TEXAS
Popular location, great lifestyle. Three busy internists seek fourth to join practice. Excellent hospital facilities and equipment. Outstanding referral base and backup. Community of 21,000 with easy access to Dallas/Fort Worth. Recreational opportunities abound - and the coverage will allow you time to enjoy it! Generous incentive package. Contact: Vicki Truitt.

D/FW METROPLEX
BC internist needed to fill the position of Director, Department of Internal Medicine of major teaching hospital. Individual selected must possess strong administrative skills, be an effective communicator, committed to primary care medicine, dedicated to quality medical education and willing to provide some direct patient care. Five day work week, superb income, benefits and UT faculty appointment will be offered to qualified individual. Contact: Jim Truitt.

SOUTH TEXAS
Thirty minutes from Padre Island. IM group, specializing in critical care, seeks third compatible associate. Great climate and lifestyle. Recreational opportunities abound. Guaranteed income with high monetary potential. Contact: Barry Strittmatter.

FORT WORTH
BC internist needed to see patients in general medicine clinics and accommodate IM consultations in community based health clinics. Five-day work week, regular hours. Superb income and benefits. Great opportunity for interesting practice and excellent life style.
Contact: Jim Truitt.

OBSTETRICS/GYNECOLOGY

NORTHEAST TEXAS
Regional medical center serving 200,000 seeks BE/BC OB/GYN for private practice (to share call with three other OB/GYNs). Can accommodate two who wish to practice together. Progressive, family-oriented community with strong diversified economy; excellent schools. Many social and recreational opportunities. Comprehensive incentive package to qualified physician. Contact: Vicki Truitt.

NORTH CENTRAL TEXAS
BE/BC OB/GYN needed for associate practice in north central Texas community of approximately 21,000 (serving referral area of 206,000). Regional medical center with ultra-modern OB facilities and equipment. Good neonatal support. Area renown for recreational facilities. Easy acess to Dallas/Fort Worth metropolitan area. Contact: Vicki Truitt.

ONCOLOGY

FORT WORTH
Full time medical oncologist needed at teaching hospital in D/FW Metroplex, clinical teaching appointment to UT medical school. Manage oncology division, develop full time oncology teaching service. Utilize modern facilities; infusion lab. Regular hours and limited call. Attractive income and benefits. Contact: Jim Truitt.

PEDIATRICS

NORTH CENTRAL TEXAS
Recently trained, BC female pediatrician seeks compatible associate for private practice. Four-way shared call; superb hospital facilities; Level II nursery. Competitive income and benefits. Attractive area with easy access to Dallas/Fort Worth. Contact: Vicki Truitt.

SOUTH TEXAS
Pediatric group practice. Three American-trained, board certified pediatricians seek compatible associate to join rapidly growing practice in the Rio Grande Valley. Excellent income potential in an area acclaimed for its great climate and recreational opportunities.
Contact: Barry Strittmatter.

NORTHEAST TEXAS
Dynamic group of American trained, BC pediatricians seek fourth associate for group practice in attractive community of 27,000 (referral area of 200,000). Progressive, family-oriented community with strong, diversified economy; excellent schools. Social and recreational opportunities abound. Modern hospital with Level II nursery and designated pediatric care unit. Shared call; excellent income and benefits; early partnership. Contact: Vicki Truitt.

PULMONARY MEDICINE

FORT WORTH
Immediate need for fellowship trained pulmonary medicine specialist to accommodate full time, 100% pulmonary and critical care consultative service. Teaching hospital, resident supervision. Limited weekend and evening call responsibility; coverage available from BC pulmonologist. Great opportunity for interesting practice with excellent life style. Good income and benefits. Contact: Jim Truitt.

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CME / Continuing Education Directory

Courses

NOVEMBER

Computer Applications

Nov 7, 1992
GRATEFUL MED: Computer Access to Information. Austin. Contact Texas Medical Association Library, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1547

General Medicine

Nov 21, 1992
Hyperlipidemia Seminar. St Louis. Contact Washington University School of Medicine, Office of CME, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Gastroenterology

Nov 20–21, 1992
What's New in Gastroenterology and Hepatology? Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX (214) 688-2166

Gynecologic Surgery

Nov 20–21, 1992
Techniques in Gynecologic Surgery. Scottsdale, Ariz. Contact Mayo Clinic, 13400 E Shea Blvd, Scottsdale, AZ 85259 (602) 391-7447

Nov 21, 1992
Flexible Office Hysterectomy. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Infectious Diseases

Nov 6–8, 1992
Infectious Disease Review. Rockville, Md. Contact Center for Bio-Medical Communication, Inc, 80 W Madison Ave, Dumont, NJ 07628 (800) 231-0389

Neurology

Nov 13–15, 1992
Update & Review in Neurology. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Obstetrics and Gynecology

Nov 3–7, 1992
Contemporary Issues & Practices in Ob-Gyn. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX (214) 688-2166

Oncology

Nov 6–10, 1992
International Symposium on Polyamines in Cancer. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Orthopedic Surgery

Nov 20–21, 1992
McKenzie Orthopaedics Seminar. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX (214) 688-2166

Otolaryngology

Nov 5–7, 1992
Otolaryngology Update. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Pediatrics

Nov 5, 1992
Pediatric Advanced Life Support Renewal Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Nov 6–7, 1992
Pediatric Advanced Life Support Provider Course. San Antonio. Contact The University of Texas Health Science Center, Office of CME, 7703 Floyd Curl Dr, San Antonio, TX 78284 (512) 567-4444

Nov 6–7, 1992
Pediatrics for the Practitioner. Irving. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX (214) 688-2166

Psychiatry

Nov 3–Dec 8, 1992 (Tuesdays, 7:30–9:30 pm)
Psychoanalytic Concepts of Character: Theory & Practice. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Nov 7, 1992
Innovations in Assessing & Treating Obsessive Compulsive Disorder. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Nov 13–15, 1992
Group Therapy Symposium. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Risk Management

From Deposition to Courtroom. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411
- Nov 5, 1992 — Tyler
- Nov 12, 1992 — Amarillo
- Nov 19, 1992 — San Antonio

Carcinoma of the Breast. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411
- Nov 4, 1992 — San Angelo
- Nov 11, 1992 — McAllen

Nov 21–22, 1992
Grand Rounds in Medical Malpractice. Dallas. Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042, (713) 789-6518

Surgery

Nov 13–14, 1992
Trauma/Critical Care Symposium for Primary Care. Dallas. Contact The University of Texas Southwestern Medical Center at Dallas, 5323 Harry Hines Blvd, Dallas, TX (214) 688-2166

Nov 20–21, 1992
Surgery Update. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

DECEMBER

Cardiology

Dec 12, 1992
Management of Hypercholesterolemia: Goals and Strategies. St Louis. Contact

Washington University School of Medicine, Campus Box 8063, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Gynecologic Surgery

Dec 11–12, 1992
Endoscopic Stapling for the Practicing Gynecologist. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Oncology

Dec 5, 1992
Laparoscopy & Thoracoscopy in Cancer Management. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Ophthalmology

Dec 10–11, 1992
Glaucoma Management. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Dec 10–12, 1992
Ophthalmic Surgical Complications. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Psychiatry

Dec 4–5, 1992
Hospital Psychiatry in the Year 2000. Houston. Contact The University of Texas Medical School at Houston, PO Box 20367, DCT S130, Houston, TX 77225 (713) 792-5346

Risk Management

Dec 2, 1992
Carcinoma of the Breast. Austin. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411

Dec 3, 1992
From Deposition to Courtroom. Abilene. Contact Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1411

Dec 5, 1992
Grand Rounds in Medical Malpractice. San Antonio. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

JANUARY

Cardiology

Jan 11–15, 1993
Cardiology Conference at Snowmass. Snowmass, Colo. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Jan 24–26, 1993
Congenital Heart Disease in the Adult. San Diego. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Gynecologic Surgery

Jan 16, 1993
Flexible Office Hysterectomy. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Infectious Diseases

Jan 14–17, 1993
Infectious Diseases Update for the Primary Care Physician. Lake Tahoe, Nev. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Obstetrics and Gynecology

Jan 21–23, 1993
Diseases of the Vulva and Vagina. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Jan 22–23, 1993
Breast Disease 1993. Houston. Contact The University of Texas Medical School at Houston, Office of CME, 1100 Holcombe Blvd, HMB 15.1509, Houston, TX 77030 (713) 792-5346

Oncology

Jan 30, 1993
Cancer Update on Melanoma/Sarcoma. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

FEBRUARY

Gastroenterology

Feb 19–20, 1993
Advances in Gastroenterology. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Neurology

Feb 11–13, 1993
Recent Advances in Neurology. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Oncology

Feb 12–13, 1993
Clinical Implications of Prostate Cancer Biology. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Pathology

Feb 11–14, 1993
Cytopathology Review Course. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Risk Management Seminars

The following courses are sponsored by the Texas Medical Association through its Practice Management Department. For further information, contact the TMA Risk Management Office, 401 W 15th St, Austin, TX 78701 (512) 370-1411.

Oct–Dec, 1992

From Deposition to Courtroom

Oct 15, El Paso
Oct 22, Dallas
Nov 5, Tyler
Nov 12, Amarillo
Nov 19, San Antonio
Dec 3, Abilene

Carcinoma of the Breast

Oct 14, Arlington
Oct 28, Wichita Falls
Nov 4, San Angelo
Nov 11, McAllen
Dec 2, Austin

Calendar of Meetings

•Denotes Texas meeting

October

Oct 22–25, 1992, San Diego
American Pain Society Annual Meeting
Contact APS, 5700 Old Orchard Rd, 1st Floor, Skokie, IL 60077-1057 (708) 966-5595

Oct 31–Nov 4, 1992, Dallas
•*Pan American Medical Association Quincentenary Congress*
Contact PAMA, 3600 Gaston Ave, Ste 1051, Dallas, TX 75246 (214) 824-2087

November

Nov 1–2, 1992, Phoenix
Leukemia Society of America Symposium
Contact LSA, 733 Third Ave, New York, NY 10017 (212) 573-8484, ext 138

Nov 5–8, 1992, St Louis
International Society for Applied Cardiovascular Biology 3rd Biennial Meeting
Contact Washington University School of Medicine, Campus Box 8063, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Nov 18–21, 1992, Houston
•*American Association for Cancer Education*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Nov 20–21, 1992, Austin
•Texas Medical Association House of Delegates Interim Session
Contact Sharon Walker (House of Delegates business) or Mrs Dale Willimack (meeting facilities and housing), TMA, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1300

Nov 27–Dec 4, Chicago
Radiological Society of North America Annual Meeting & Scientific Assembly
Contact RSNA, 2021 Spring Rd, Ste 600, Oak Brook, IL 60521 (708) 571-2670

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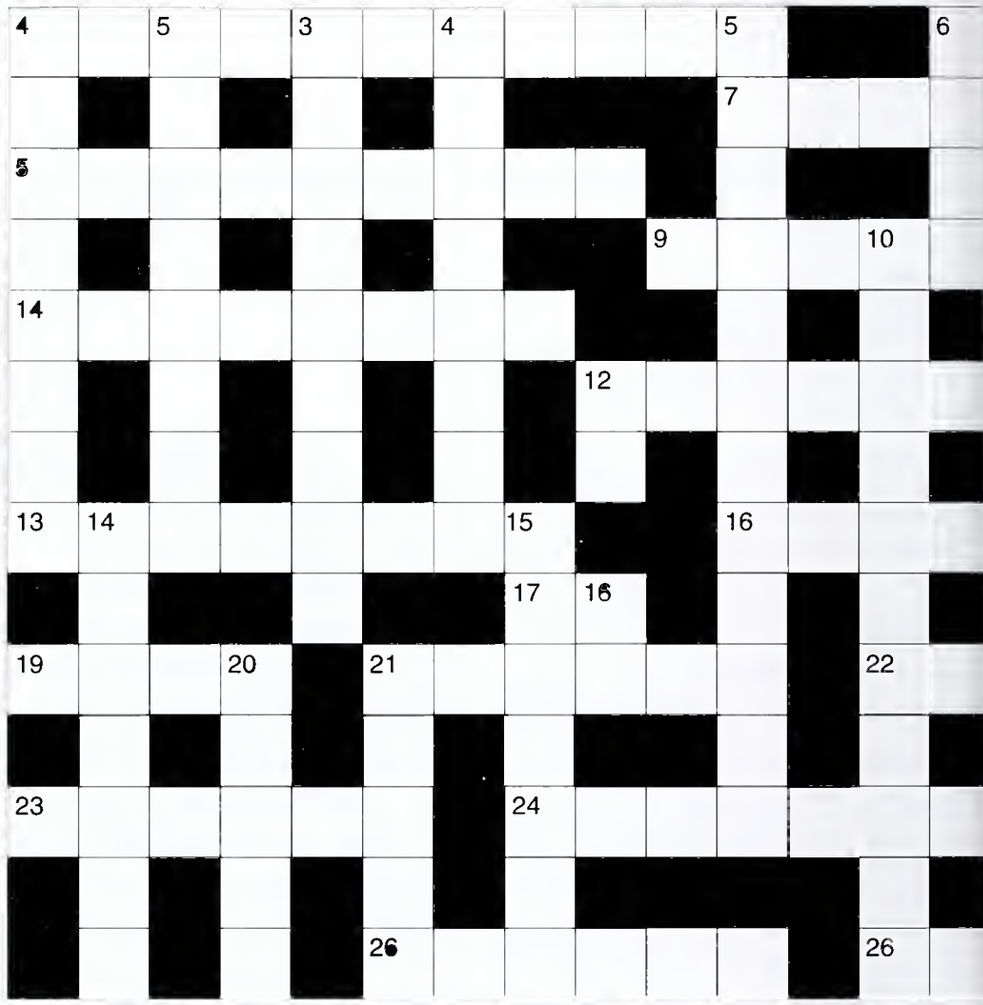

ACROSS

1. Flat sheet of white fibrous tissue that serves as a muscle attachment (11)
7. An aromatic balsam. An ingredient in linctus preparations (4)
8. The dividing wall of dura mater between the cerebrum and the cerebellum (9)
9. A drug that causes strong sustained contraction of muscle, especially of the uterus (5)
11. A gap in memory (8)
12. Lack of oxygen to an organ or tissue (6)
13. A regard for the well- being of other people (8)
16. Gestation period expressed in calendar months (4)
17. Before food (2)
19. A powerful astringent and styptic, composed of aluminum and potassium sulphate (4)
21. The tissue that grows around fractured ends of bones and develops into new bone to repair the injury (6)
22. Prefix meaning toward (2)
23. A factor found in vitamin B complex (6)
24. A substance capable of burning organic tissue (7)
25. Condition (6)
26/ 18 Down. An isotonic solution (2,2)

DOWN

1. Loss of tone (8)
2. An external application with a base of lard, lanolin or petroleum jelly in which the remedy is incorporated (8)
3. Of external origin (9)
4. Inflammation of the mucous membrane of the nose (8)
5. The identification of objects through the sense of touch (12)
6. A tube or channel for conveying away the secretion of a gland (4)
10. A sense of direction (11)
12. Prefix meaning away (2)
14. A continuous repetitive, wordless sound as made by infants (7)
15. Softening of tissues (7)
18. See 26 across (2)
20. The viscid secretion of mucous membranes (5)
21. Receptor end organs in the retina (5)

Solution on p 26.

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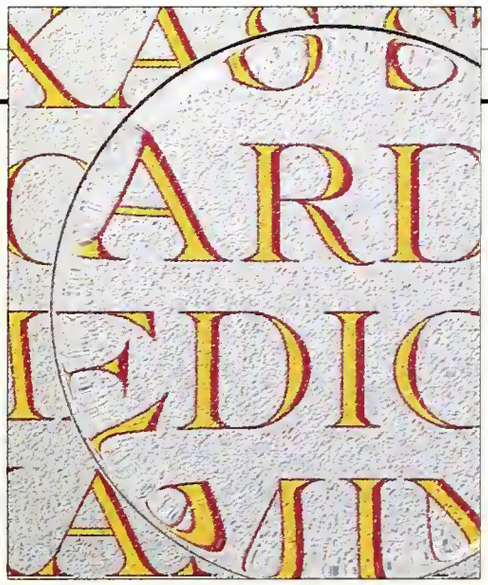

Cover production by Mike Curtis.

T *e x a s* **M** *e d i c i n e* **F** *e a t u r e*

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"Make no mistake about it: the legislative examination of the TSBME is politically driven."

Under the microscope: Texas State Board of Medical Examiners

The agency that licenses and disciplines Texas physicians faces intense scrutiny as it comes under "sunset" review by the legislature in 1993.

BY KEN ORTOLON

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Upfront

AMA president urges Texas physicians to stand together
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Public Health

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Physicians discover maze of regulations under ADA
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The Journal

Smoking cessation interventions by family physicians in Texas
By Jack L. Franklin, PhD; Anna Fay Williams, PhD; G. Michael Kresch; Joseph T. Painter, MD; Karen Torges; Jim White; Owen Grossman, MD

Dicyclomine for medical management of persistent anal fissure with associated spasm of the internal sphincter
By Lucinda G. Miller, PharmD, BCPS; John C. Rogers, MD, MPH; Ervin B. Brown, MD, FACS; Gayle Perkins, PA

•••

START THE HEALING NOW

•••

TMA program spells out what you can do about family violence

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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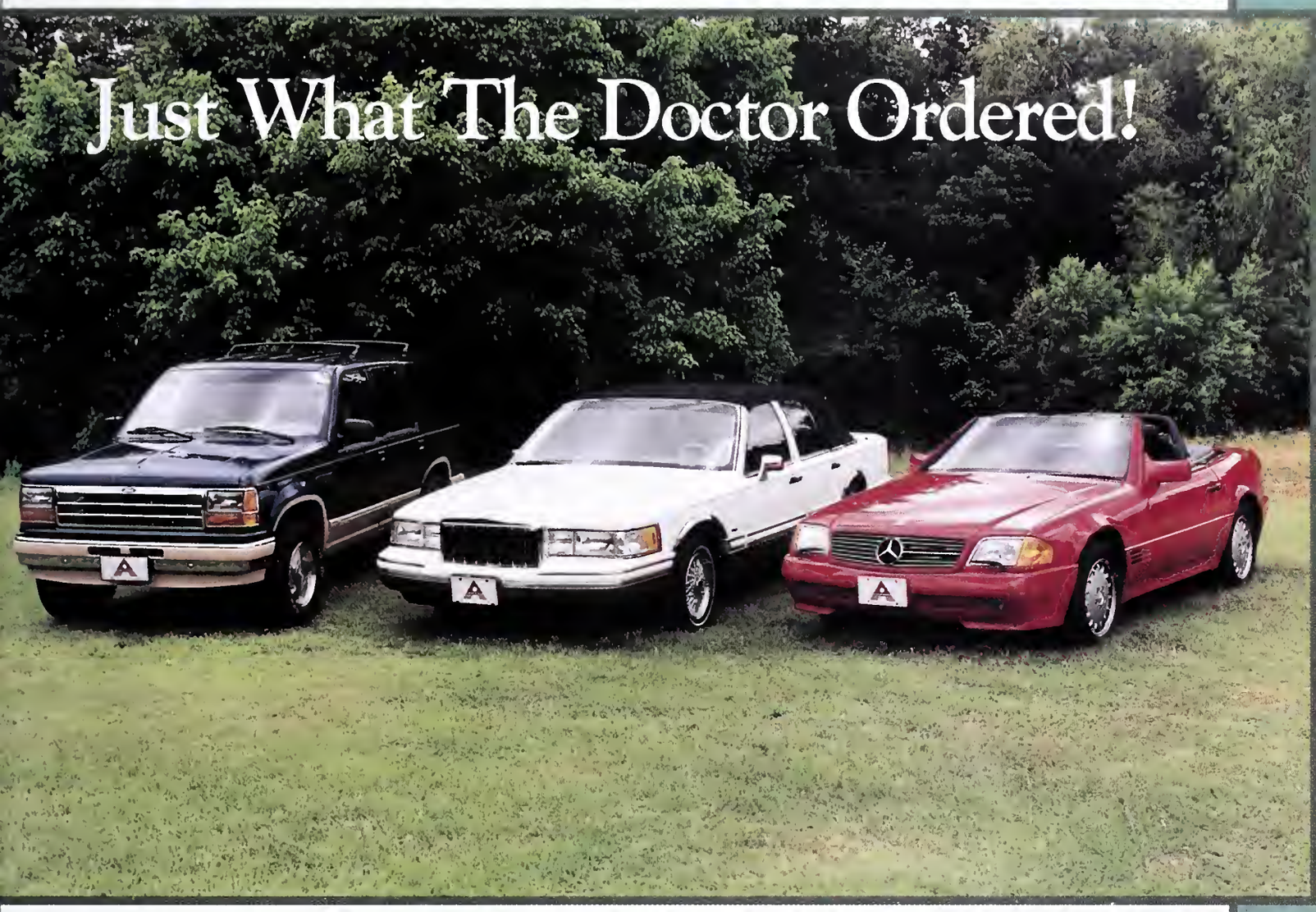

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Letters

Physicians must remain the decision-makers

I TAKE EXCEPTION TO DR Powell's comments regarding the need for practice guidelines to ration health-care technology (Letters, *Texas Medicine*, September 1992, p 7). He leaves the impression that all physicians are mindlessly overutilizing the full gamut of available technology without regard for individual circumstance. Throughout residency, I have been trained to base patient management decisions on clinical judgment derived from objective assessment of available data for the individual case, supported by available literature when applicable.

While I agree the legal system has tended to force physicians into ordering large numbers of tests to "cover all the bases," I feel most prudent physicians can and should take responsibility for making well-informed decisions about who gets what care. The last thing our health-care system needs is yet another bureaucratic agency striving to make the already difficult task of practicing clinical medicine more complex by adding new rules in an attempt to save money by limiting patient care options. The more that physicians are willing to let third parties make these decisions, the weaker our organized efforts will be to change the system for the benefit of all involved.

Jerry Day, MD
The University of Texas
Southwestern Medical Center at Dallas
Department of Neurological Surgery
5323 Harry Hines Blvd
Dallas, TX 75235-8855

Rural medical practice: the voice of experience

AFTER 40 YEARS OF PRACTICE in West Texas, I feel qualified to speak up about rural medicine.

I have had the unique opportunity to work in rural areas all over the state as a locum tenens for 5 years, followed by a similar period of full-time general practice in Sundown. As I approach retirement, I wish to share what I have learned from rural practice with other physicians, especially those young family physicians who are contemplating solo practice where they are really needed.

The areas hardest hit by the so-called "doctor shortage" have a population of 2,500 or less — not enough to support two physicians but almost too much for one, considering that he will have no relief for CME or vacations unless he employs a locum tenens to cover for him, which is a very expensive option.

Maintaining hospitals in towns of this size is not viable. Such hospitals are underutilized, poorly staffed, and they eat the taxpayers alive. Rarely were any of the small-town hospitals in which I worked at more than 20% capacity, and most of the patients were "swing" patients or accident victims. The idea that throwing money at the problem will solve it is a fallacy.

The solution, as I see it, is to persuade more young family doctors to locate in small towns and to devote their careers to practicing medicine where they are really needed. With the help of a trained EMT squad — already present in most small towns — patients who need it can be transported to the nearest medical center quickly. Helicopter service is available for critical cases. If the town has no pharmacy, the physician is permitted by law to have his or her own, which can be a valuable economic asset.

Incidentally, a husband-wife doctor team is an ideal combination for small-town practice.

Some modification of the Canadian health-care plan may eventually be needed to provide care to underserved areas. The use of physician assistants or nurse practitioners should also be considered, and, in fact, this is already done in some places.

One thing is certain: The doctor who goes solo in a small town will never be called by the revolting appellation, "provider."

And, lest some believe I am asking too much in the name of humanitarianism, 100K per year, net, is possible.

Robert Franken, MD
Sundown Family Medical Clinic
PO Box 205
Sundown, TX 79372

There's more to 'what our patients are reading'

"A DOSE OF INFORMATION: What are your patients reading?" (*Texas Medicine*, September 1992, pp 36–42) was timely and well done. I note two significant types of medical information that are not mentioned:

1. The reports generated by malpractice lawsuits and the media presentations by lawyers to attract clients with alleged health or injury problems. Our patients are exposed to a large amount of this daily. Significant distortions of medicine are presented by reporters and the purchasers of the advertising.

Express your point of view in Texas Medicine

To submit a letter, send it to Texas Medicine, *TMA, 401 W 15th St, Austin 78701. Please type letters you submit for publication, and keep the length to 400 words or less. If necessary, you may include a few references, preferably less than five. Letters are published at the discretion of the managing editor and editorial advisors, and are subject to editing and abridgment. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Texas Medical Association.*

2. The "silicone problem" was one of the biggest media events this year. Reporting varied from very good to totally irresponsible. Many stories promoted anxiety to the point of hysteria in patients with silicone implants, produced no new scientific knowledge, offered no solutions, and produced a new theory for trial lawyers. The real story of how government (in this case, the US Food and Drug Administration) is controlling medical practice was hardly touched. So big an event and not mentioned in the article. Maybe next time.

John E. Carter, MD
7711 Louis Pasteur Dr
San Antonio, TX 78229

New group seeks medical relief mission participants

I WOULD LIKE TO LET TEXAS physicians know of a newly formed group, Doctors for a Better World (DBW). This organization was created following my experiences in a MASH hospital in the Persian Gulf war where I developed an interest in medical humanitarian work. At the present time, DBW can only be described as a fledgling organization, really an idea looking for participants.

My hopes are to create a network of physicians and nurses who can organize and execute medical relief missions. While I am an anesthesiologist and naturally have an interest in creating surgical teams, primary care can and should be a part of every mission. Examples of types of missions we might undertake include trips to perform cataract surgery, repair of cleft lips, and orthopedic surgery for children with congenital deformities. Missions are limited only by a willingness to do them. Details of each mission —intent, location, overall planning — would be formulated by team members. We are currently seeking tax-exempt status for DBW.

I am interested in hearing from physicians who would be willing to volunteer on projects with Doctors for a Better World. The address for DBW will change after December 31, 1992, to 5554 Buckley, El Paso, TX 79912.

Monte Ladner, MD
5525 N Stanton #7D
El Paso, TX 79912

Abortion's legality does not make it moral

I WOULD LIKE TO RESPOND TO the letter by Dr Greenberg in the September issue of *Texas Medicine* (pp 9–10) in which he denounces "religious zealots" for harassing a Richardson physician. Although I do not have enough information on the Richardson case to comment on the tactics of those particular pro-life activists, I would like to point to the fallacy of Dr Greenberg's argument.

Just because a medical practice or procedure is legal (or politically correct) does not necessarily make it moral or right. The prime example of this is the experimentation on concentration camp prisoners by German physicians during World War II. By our standards today, that practice was abhorrent and immoral. Who knows how history will judge the current practice of abortion on demand?

Pro-life activists strongly believe that each human life is of value and that abortion is essentially destroying a human life. Such a belief logically results in activities to limit or restrict abortion on demand. Just as the antislavery movement in the 19th century sought to eliminate a legal slave industry, pro-life activists have used many strategies to further their cause.

The tactic of bringing shame to physicians who perform abortions seems justifiable when compared with the destruction of an innocent human embryo or fetus. If abortionists feel they have the moral high ground, then why should they care what a few "fanatics" say?

It is interesting that when a woman is pregnant and the baby is wanted, modern medicine uses all its resources and efforts to nurture and sustain this human life. However, when the mother does not want to be pregnant, then this developing life becomes a nonhuman life that can so easily be destroyed. How can medicine maintain its primary goal of "do no harm" with this mind-set?

It is my opinion, and the opinion of many other Texas physicians, that the current policy of unrestricted abortion-on-demand is morally wrong and that organized medicine's support for the "woman's choice" to destroy a human life is the antithesis of what the healing profession should stand for.

Christopher P. Dehan, MD
Austin Ear, Nose & Throat Clinic
3705 Medical Parkway, Suite 320
Austin, TX 78705

So-called health-care crisis has solutions

(Editor's note: The following letter is a portion of correspondence to US Rep Larry Combest from John H. Selby, MD, former chairman of the TMA Council on Socioeconomics.)

ONE OF THE MAJOR ISSUES in the upcoming campaign will obviously be health care and how it should be managed. Our present situation has been referred to as a health-care crisis. In my opinion, it is not so much a health-care crisis as a financial crisis.

It is intolerable to spend 12% to 13% of our gross national product for health care, particularly when no one is happy with the system. Patients are suffering from high costs, doctors are unhappy because we are swamped with paperwork and government harassment, and businesses are unhappy because of the tremendous expense of supplying health care to employees.

Four factors combine to increase medical costs:

1. Liability insurance.
2. Health insurance costs, which leave a large number of Americans uninsured.
3. Medical fees and hospital costs.
4. The change from professionalism in medical practice to a business environment.

To address the liability insurance factor, there must be tort reform. We need a board of adjudication, made up of consumers, providers, and medical specialists who could evaluate a liability case from the factual standpoints rather than from the subjective and often emotional standpoint of a jury. This board could make recommendations to the plaintiff, defendant, and jury.

Additionally, there must be a limit on attorney's contingency fees and a significant responsibility for those who file frivolous suits.

Insurance costs would be lowered by the above approach because a board of adjudication would cut down on the tremendous liability of the insurance coverage. Defensive medicine, which adds a large amount to the cost of care, would also be cut because physicians would realize they could expect a fair evaluation.

Insurance costs should be controlled by the free enterprise system in competition. Those companies that pay adequately for injury and charge lower premiums would prosper rather than those that deliver the most money to their stockholders or spend the most on advertising and promotion.

Physicians' fees and hospitals' costs certainly have escalated, but this is in part due to government interference. Congress must reverse the control of the Federal Trade Commission. Professional organizations and peer pressure can exert some control over quality and fees of their members if given the proper authority.

I am a firm believer in the free enterprise system and I believe that open competition can bring about the most reasonable and best medical care, provided that competition is undergirded with a strong ethical basis and a good moral background.

John H. Selby, MD
4809 University, Suite 201
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Upfront

AMA president urges Texas physicians to stand together

"IN THE RACE FOR QUALITY, there is no finish line," said John L. Clowe, MD, president of the American Medical Association, in the opening address at the 1992 TMA Fall Leadership Conference held in Austin, September 19.

"But I don't have to tell you that as change has eaten away at our clinical autonomy, and nibbled away at our ability to police our own profession, and gnawed away at the sanctity of the physician-patient relationship, it has gotten harder and harder to ensure the quality of medicine in America," he said.

Dr Clowe, a Schenectady, NY, family practitioner who took office in June, told participants that the medical profession was itself partly responsible for the recent flood of regulatory hassles such as CLIA, OSHA, and safe harbor regulations.

"Regulations usually spring to fill a vacuum," he said. "And we've left a lot of vacuums over the years. We didn't police our own laboratories. We didn't adequately ensure the safety of our coworkers. We've allowed unconscionable joint ventures and self-referral schemes to develop. We've left the door open, and now we are paying the price of external regulation."

To repair the damage, he said, "We must enhance the professional standing of physicians."

One of the tools needed for that enhancement, according to Dr Clowe, is "the right to regulate ourselves without fear of lawsuits or running afoul of the antitrust laws." The AMA has petitioned the Federal Trade Commission to change its interpretation of the antitrust laws to allow physicians greater freedom to review physician fees and practices and to impose their own discipline.

TMA President William G. Gamel, MD, Austin, introduces John L. Clowe, MD, president of the American Medical Association, at the TMA 1992 Fall Leadership Conference, which more than 850 physicians attended.

But physicians cannot expect to have autonomy to direct their profession unless they remain unified, said Dr Clowe. "We must draw more and more physicians into professional activities . . . . By joining us, all the doctors in Texas will be heard and will have an influence in ensuring quality medicine."

Endowment will 'spread the news that physicians care'

THE CAMPAIGN TO create A Legacy of Caring Endowment needs the support of all Texas physicians so more of the state's critical public health problems may be addressed.

More than 700 physicians already have pledged nearly $5 million dollars to the Legacy fund, a permanent endowment of the Texas Medical Association Education and Research Foundation. (See list of contributors on pp 14–15.) The interest the fund earns will pay for crucial public health and medical education projects throughout the state —projects like border health education, health services for teens in crisis, and access to quality care.

"Texas physicians, through this endowment, are creating a legacy for the people of Texas — for the patients we see and those we don't, and especially for new Texans born every day," Alan C. Baum, MD, Houston, chairman of the TMA Board of Trustees, told contributors at a reception in September.

The first project funded through the endowment was a joint effort with the El Paso City-County Health Department. The massive public awareness project involves volunteers from the TMA Alliance in pro-

Gathered at a reception during the TMA Fall Conference in September to celebrate the success of A Legacy of Caring campaign are, from left, Leena N. Shroff, MD, Midland; Dr and Mrs Bernard W. Palmer, San Antonio; and Nick N. Shroff, MD, Midland. Dr Palmer is chairman of the TMA Development Committee.

viding information door-to-door to people living in the *colonias* about cholera, immunizations, cancer, and other concerns.

All TMA members will receive information about the fund with their dues statements later this month. Contributions of all amounts are welcomed, but gifts of $1,000, $500, $200, and $100 are suggested. Donors who pledge $1,000 or more receive recognition on the donor wall in the Texas Medical Association building.

For further information about supporting A Legacy of Caring, contact the TMA Resource Development Department, 401 W 15th St, Austin, TX 78701, phone (800) 880-1300 or (512) 370-1370.

What's so funny about medicine? *Texas Medicine* wants to know

A PATIENT WALKED INTO A psychiatrist's office and said: "Doc, I'm confused. Some days I think I'm a wigwam, other days I imagine I'm a tepee. What's my problem?"

The doctor pondered the question and answered: "It's simple. You're two tents."

All kidding aside, humor in medicine is serious business. Studies have shown that the appropriate use of humor can have a therapeutic effect on gravely ill patients. Trauma surgeons find it invaluable in calming accident victims. And many physicians credit their sense of humor as the only thing that got them through the first year of residency.

In a future issue, *Texas Medicine* will examine humor in medicine, from its therapeutic use in the office and hospital to how physicians use it daily to help patients and themselves cope with the stresses of medicine.

But we need your help. Do you know a colleague or mentor who effectively uses humor in his or her practice? Can you recall a time when humor helped you with a difficult situation in your practice? Do you know any good doctor (or lawyer) jokes?

If so, contact Associate Editor Mark Richardson at (800) 880-1300, or (512) 370-1383. Better yet, write down your information and fax it to him at (512) 370-1632.

But don't delay. You know what happens to doctors with no sense of humor? They lose their patients . . .

TMA travel program sets destinations for 1993

THE TMA TRAVEL PROGRAM means Texas physicians can indulge in more than a fantasy about escaping the hassles of medical practice. Trips are scheduled throughout the year and to points all over the world, including, for the first time, trips to the Canary and Galápagos Islands.

Trips planned for 1993 include:

- South Pacific (Fiji; Australia; New Zealand): January 30–February 15.
- Trans-Panama Canal (Acapulco; Costa Rica; Transit Panama Canal; Jamaica; Grand Cayman Island; Mexico; Florida): January 19–30 and March 13–24.
- Antarctica (from Santiago, Chile, past Cape Horn and across Drake Passage to Antarctica): February 3–17.
- South Africa (Johannesburg; Durban; Cape Town; Blue Train): February 11–24.
- Wings Over Nile (Cairo; Luxor; 4-night cruise of the Nile; Aswan; Hurghada): February 26–March 10.
- Costa Rica and Galápagos Islands (San Jose, Costa Rica; Guayaquil, Ecuador; Galápagos Island cruise): March 17–28.
- Canary Islands (Canary Islands; Morocco; Gibraltar; Spain): April 17–29.
- Dutch Waterways Adventure (Amsterdam; cruise waterways of Holland; Paris; Geneva): May 23–June 5.
- Journey of the Czars (Shannon, Ireland; Moscow; St Petersburg; 7-night cruise on Volga, Svir, and Neva Rivers): June 26–July 11.
- Midnight Sun/Alaska Passage (Fairbanks; Midnight Sun Express train ride/Denali National Park; Anchorage; cruise Inside Passage to Vancouver): July 10–22 and August 23–September 4.
- Danube River Adventure (Vienna; cruise seven countries on Danube River; Istanbul): July 12–26 and August 29–September 12.
- Scandinavia (Copenhagen, Denmark; Oslo, Norway; Gudvangen, Bergen, and Stockholm, Sweden): July 11–23 and August 15–27.
- Canadian Rockies (Calgary; Glacier National Park; Lake McDonald; Lake Louise; Jasper; Banff): July 26–August 4.
- Mediterranean/Black Sea (Air and sea cruise — Italy; Malta; Crete; Greece; Turkey; Ukraine): August 17–31 and August 30–September 13.
- Wings Over Kenya (Nairobi, Amboseli National Park, The Ark, Samburu National Reserve, Masai-Mara National Reserve): September 6–19 and September 24–October 7.
- Passage to Suez (Turkey; Greek Islands; Israel; Egypt): October 12–26.
- China/Yangtze River Adventure (Japan; China — Beijing, Chongqing, 3-night Yangtze River cruise, Xian, Shanghai; Hong Kong): September 22–October 8.
- Concorde Safari (from Cairo to East Africa to South Africa aboard the Concorde): October 21–November 11.
- Tiger Tops (Thailand; Nepal; India): October 30–November 15.

Continuing medical education programs are scheduled on some of the trips.

For further information on the travel program, contact Jeanette Prentice, TMA Travel Program, 401 W 15th St, Austin, TX 78701, (800) 880-1300 or (512) 370-1565.

TMA competition seeks top medical stories

TEXAS MEDICAL ASSOCIATION is calling on all reporters to submit their best 1992 health or medical story to its 36th Anson Jones Award competition. The association also wants physicians to encourage worthy reporters to enter the coveted award competition. The Anson Jones Award recognizes excellence in communicating health and medical information to the public.

A "call for entries" will be mailed in November to Texas radio and television stations and newspapers; consumer magazines; and company, trade, chamber, and association employee publications. County medical societies also will receive a copy. The deadline for entries is January 11, 1993.

Persons in the medical field or from medical and health-related institutions are not eligible for the competition.

The media award, a project of the TMA Council on Communication, is named for Anson Jones, MD, a pioneer Texas physician who served the Republic of Texas with distinction as a member of Congress, secretary of state, and its last president.

Winners in each of 15 categories receive a $500 cash award and framed certificate. Spanish language entries may be submitted in a separate category. Winners will be recognized at the TMA Annual Session next May in Houston. Citations of merit may be awarded as well; each merit citation winner receives a framed certificate.

Additional information and entry forms are available from the TMA Public Relations Department, 401 W 15th St, Austin, TX 78701, phone (800) 880-1300 or (512) 370-1389. ★

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Crossword puzzle on p 80.

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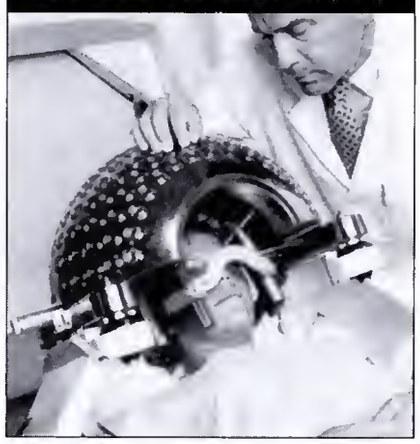

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A Legacy of Caring

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Many physicians and friends have generously supported "A Legacy of Caring". Contributors pledging before October 1, 1992 are listed below by donor category. Contributors of $1,000 or more will be permanently recognized on a donor wall in the TMA building. Donors will continue to be recognized in Texas Medicine.

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The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Usage in Pregnancy: Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. 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Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). 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Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, (cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

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People

NEWSMAKERS

Orval Brown, MD, associate professor of otorhinolaryngology at The University of Texas Southwestern Medical Center, has been elected president of the Society for Ear, Nose and Throat Advances in Children.

The 1992 recipients of the Texas Academy of Family Physicians/Upjohn Award for Outstanding Family Practice Residents include **M. Eileen Conner, MD; Lynda B. DeArmond, MD; Susan M. Garton, DO; Mark Gillet, MD; John S. Volk, DO;** and **Wesley D. Wylie, MD.**

Michael DeBakey, MD, chancellor of Baylor College of Medicine and director of The DeBakey Heart Center at The Methodist Hospital and Baylor College of Medicine, was inducted into the Academy of Athens, a society of scholars founded by the Greek philosopher Plato. The induction ceremony was held during a symposium on the advances in cardiovascular and thoracic surgery, which launched a program to promote the exchange of medical information between Houston physicians and Greek doctors.

Brownsville occupational and environmental medicine specialist **Margaret R. Wells Diaz, MD, MPH,** was appointed to the Border Advisory Committee of the Environmental Protection Agency.

Otolaryngologist-head and neck surgeon **Donald T. Donovan, MD,** Houston, was among 23 surgeons to receive the American Academy of Otolaryngology-Head and Neck Surgery's Honor Award.

Mark A. Doyne, MD

Mark A. Doyne, MD, medical director of the Texas Back Institute in Plano, was elected to the board of directors of the American College of Physician Executives.

The Texas College of Emergency Physicians appointed **James E. Hayes, MD,** Dallas, president of the organization. Other elected officials include Houstonians **Arlo F. Weltge, MD,** as president-elect and **Diana L. Fite, MD,** as secretary, and **William L. Moore, MD,** Tyler, for treasurer.

Dallas cardiologist **Bob Hillert, MD,** received the Paul V. Ledbetter, MD, Medical Professional Volunteer of the Year award from the American Heart Association.

Robert Jimenez, MD, medical director of adult psychiatric services at Charter Real Hospital in San Antonio, was appointed to the board of the Partnership for Hope, a research and community planning project to reduce chronic poverty.

Houston emergency medicine specialist **Regina F. Kyles, MD,** was appointed to the Texas State Board of Medical Examiners by Gov Ann Richards.

Director of the Harold C. Simmons Comprehensive Cancer Center at The University of Texas Southwestern Medical Center, **John D. Minna, MD,** received the C. Chester Stock Award from the Memorial Sloan-Kettering Cancer Center for his efforts in advancing cancer knowledge.

Frank G. Moody, MD, chairman of the department of surgery at The University of Texas Medical School at Houston, received the Olof Acrel Medal for his worldwide contributions to the practice of surgery. Dr Moody also was named Professor Honorario at the Hospital Universitario Doce de Octubre in Madrid for presenting the United States' view of surgical treatment of diseases of the bile ducts, pancreas, and esophagus, and morbid obesity to the XV Curso Internacional de Actualizacion En Cirugia.

Gyman C. Okeson, MD, chief of the section of pulmonary rehabilitation at Scott and White in Temple, was elected second vice-chair of the board of the American Lung Association of Texas.

Nick Paslidis, MD, PhD

Nick Paslidis, MD, PhD, The University of Texas Health Science Center at Houston internal medicine department, was selected as one of 50 resi-

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Criteria for inclusion in the Newsmakers section are: TMA member; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, Texas Medicine, *401 W 15th St, Austin, TX 78701.*

dents nationwide to receive the Research Award for Clinical Trainees from the National Institutes of Health. The award recognizes the contributions of young physician scientists and assists with their academic endeavors.

William L. Risser, MD, director, division of community and general pediatrics at The University of Texas Medical School at Houston, was elected chairman of the Committee on Sports Medicine and Fitness of the American Academy of Pediatrics.

John A. Rush, Jr, MD, director of the Mental Health Clinical Research Center at The University of Texas Southwestern Medical Center, received The Institute of Pennsylvania Hospital Award for his contributions to psychiatric patient care and treatment.

In recognition of his accomplishments in neurosurgery, **Raymond Sawaya, MD,** The University of Texas M.D. Anderson Cancer Center, received the Wilder Penfield Award from the American University of Beirut.

The American Urology Association gave **Peter Scardino, MD,** the Article Most Helpful to Clinical Urologists Award for the publication of "Early Diagnosis of Prostate Cancer Vital to Cure the Disease," in their monthly journal. Dr Scardino is chief of The Methodist Hospital's urology service and chairman of the urology department at Baylor College of Medicine in Houston.

Edward B. Singleton, MD, is the 1992 recipient of the Gold Medal of the Society for Pediatric Radiology. Dr Singleton is chief of diagnostic imaging at Texas Children's Hospital in Houston and professor of radiology at Baylor College of Medicine.

San Angelo internist **Dan Stultz, MD,** received the Distinguished Alumni Award from The University of Texas Medical School at Houston.

Robert E. Sullivan, MD, La Marque, was awarded the Texas Academy of Family Physician's highest honor, Texas Family Physician of the Year.

Rosa A. Tang, MD, was named the 1991–1992 outstanding faculty member of the department of ophthalmology at The University of Texas Medical Branch at Galveston. Dr Tang is a clinical professor at UTMB and The University of Texas Medical School at Houston.

Dallas surgeon **Erwin R. Thal, MD,** medical director of the surgical emergency room at Parkland Memorial Hospital and professor of surgery at The University of Texas Southwestern Medical Center, received the Distinguished Achievement Award from the American Trauma Society for improving trauma care and prevention.

Madhukar Trivedi, MD, assistant instructor in psychiatry at The University of Texas Southwestern Medical Center, was selected as a National Alliance for Research on Schizophrenia and Depression Young Investigator.

R. James Valentine, MD, Dallas, assistant professor of surgery at The University of Texas Southwestern Medical Center, has been appointed the Royal College of Surgeons Foundation Inc Merck Traveling Fellow for 1992. This grant allows him to observe the practice and teaching of vascular surgery in Great Britain.

Otto L. Willbanks, MD, Dallas, is president-elect of the American Society for Bariatric Surgery. Dr Willbanks is a clinical professor of surgery at Baylor University Medical Center and at The University of Texas Health Science Center at Dallas.

Marion Worthington, MD, director of the Women's Admission Unit for Kerrville State Hospital, received the National Alliance for the Mentally Ill Exemplary Psychiatrist Award.

OBITUARIES

Doris Jean Adam, MD, 66; Dallas; The University of Texas Medical Branch at Galveston, 1949; died July 18, 1992.

May B. Bachtel, MD, 87; Huntsville; The University of Texas Medical Branch at Galveston, 1939; died August 24, 1992.

Ben Thomas Blackwell, MD, 89; Amarillo; The University of Texas Medical Branch at Galveston, 1934; died August 12, 1992.

Mason Eugene Brock, MD, 74; Kingsland; Tulane University, 1950; died July 31, 1992.

Eugene T. Ellison, Sr, MD, 81; Texarkana; Vanderbilt University, 1934; died August 25, 1992.

Eva T. Everett, MD, 73; Bridge City; The University of Texas Medical Branch at Galveston, 1948; died April 20, 1992.

David Allan Franklin, MD, 33; Baytown; Baylor College of Medicine, 1985; died August 6, 1992.

John P. Gorman, MD, 56; Houston; Santiago De Chile, 1965; died April 28, 1992.

FORMER TMA PRESIDENT DURWOOD E. NEAL, MD, DIES

DURWOOD E. NEAL, MD, president of Texas Medical Association during 1980–1981, died September 6, 1992, at the age of 71.

A Fort Worth family practitioner, Dr Neal received TMA's highest honor, the Distinguished Service Award, in May 1991.

He was a past chairman of the TMA Council on Communication and was a member of the Council on Annual Session and Scientific Programming.

He served as president of the Tarrant County Medical Society in 1974 and was a member of its board of trustees. Dr Neal also was a past president of the Texas Academy of Family Physicians and was named Texas Physician of the Year by the academy in 1986.

He served as a trustee of the Texas Medical Foundation, as the medical director of Hospice Care in Fort Worth, and on the medical staff of three local hospitals.

Dr Neal was born in Arkansas in 1921. He received his medical degree from The University of Arkansas in 1945 and served an internship and residency at John Peter Smith Hospital in Fort Worth.

He is survived by his wife, Nell Neal, and children, Durwood E. Neal, Jr, MD; Jack McMahon, PhD; Jan Renfro; Chuck Oswalt, MD; Chip Oswalt, MD; Judy Swift; Bill Oswalt, MD; and Barry Oswalt, MD.

George A. Gray, MD, 94; Dallas; Baylor College of Medicine-Dallas, 1926; died August, 1992.

Charles Durwood Hendry, MD, 60; Tyler; The University of Texas Southwestern Medical School, 1964; died August 9, 1992.

Nicholas C. Hightower, Jr, MD, 73; Temple; The University of Texas Medical Branch at Galveston, 1944; died August 22, 1992.

Jack R. Hild, MD, 88; Houston; Tulane University, 1929; died August 24, 1992.

Joseph Lee Karkowski, MD, 54; Houston; University of Oklahoma Health Sciences Center, 1969; died August 18, 1992.

B.H. McVicker, MD, 70; Lufkin; Baylor College of Medicine, 1947; died August 21, 1992.

Julius Francis Marlowe, Jr, MD, 59; San Antonio; Vanderbilt University, 1957; died August 29, 1992.

Wilson O. Wagner, MD, 77; Dallas; The University of Texas Medical Branch at Galveston, 1942; died July 26, 1992.

Charles D. Walther, MD, 69; Nederland; University of Rochester, 1947; died August 13, 1992.

Robert Bruce Wilson, MD, 66; Houston; Baylor College of Medicine, 1954; died August 17, 1992.

Benjamin E. Zimmerman, MD, 64; Mansfield; University of Arkansas, 1954; died August 10, 1992.

FORMER TMA BOARD OF TRUSTEES CHAIRMAN CHARLES P. HARDWICKE, MD, DIES

CHARLES P. HARDWICKE, MD, chairman of the Texas Medical Association Board of Trustees during 1969–1971 and an emeritus member of the association, died August 20, 1992. He was 90.

Dr Hardwicke was vice-speaker of the TMA House of Delegates from 1954 to 1957, served as speaker from 1958 to 1961, and as treasurer from 1971 to 1974.

A retired colon and rectal surgeon, Dr Hardwicke practiced medicine in Austin for more than 50 years. He graduated from The University of Texas Medical Branch at Galveston in 1926 and served an internship in Kansas City (Mo) General Hospital. He served in the United States Army in the Pacific during World War II.

He was a past president of the Travis County Medical Society, a member of its board of directors, and the first chairman of the TCMS Foundation board of trustees.

Dr Hardwicke's survivors include his wife, Maurine R. Hardwicke, daughters and sons-in-law, Ann and Dan Moody, Jr, and Mary and Courtney Townsend, Jr, MD; and grandchildren.

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Public Health

Start the Healing Now: TMA begins series on domestic violence

IT'S AN EPIDEMIC THAT recognizes no economic or social boundaries. It strikes women, men, children, and the elderly. And one or more of your patients may be a victim of this tragedy that is plaguing the state.

"As physicians we are often on the front line of dealing with victims of family violence," says Fort Worth allergist Susan Rudd Wynn, MD, who chairs the TMA Council on Communication. "Most of us will admit we are ill-prepared to recognize, treat, or confront the problem."

To provide doctors with the necessary tools to combat domestic violence, the communication council developed a series of awareness and educational programs. The first session, "Start the Healing Now: What You Can Do About Family Violence," was presented at the TMA 1992 Fall Leadership Conference in September and featured a panel of experts who addressed topics such as sexual assault of children, elder abuse, and domestic violence in intimate relationships.

"Traditional medical education may have taught us how to heal the black eyes and broken bones," said Dr Wynn, who chaired the panel. "But often we are not prepared to look beyond these injuries for their basic causes."

Searching beyond the obvious

Through the years as an emergency room physician in Houston, panelist Diana L. Fite, MD, has treated her share of the physical and mental injuries inflicted upon women and children.

Susan Rudd Wynn, MD, Fort Worth, left, discusses with Diana L. Fite, MD, Houston, the TMA Council on Communication education session on family violence held at the TMA Fall Leadership Conference in September.

Many of the women who are victims of abuse seek refuge in the confines of a hospital emergency department. They are in search of safety not only for themselves, but also for their children.

"When you are sewing up lacerations, it's easy to determine that this patient is a victim of abuse," says Dr Fite, who chairs the Harris County Medical Society domestic violence prevention program. The hard cases to identify, however, are those such as "the victim who comes in week after week with complaints of headaches and stomachaches, but you never find anything wrong during a physical exam, or the mother who brings her child to the ER at 2 am with complaints, but you can't find anything wrong."

These types of situations should send up a red flag alerting the physician to the fact that he or she may be treating a victim of abuse. "It's their way of crying out for help," says Dr Fite. "And it's not fair when you are safer walking the streets of Houston, Texas, at 2 am, than you are in your own home."

Planting the seeds of guidance

Anna Belle Burleson of Austin lived in a world of domestic violence for 6 years. She has now escaped the chains that bound her to the physical and mental anguish she experienced at the hands of her husband.

One of the greatest hurdles a woman in a violent relationship faces is making the decision to leave. The next step is to seek help. Ms Burleson, who chairs the Former Battered Women's Task Force, told participants on the panel that she believes doctors are in a unique position to break the cycle of violence.

"Physicians are able to interact with victims of domestic violence in a real unique way," she said. "You have the opportunity to plant seeds in their heads and start giving patients the information and facts they need that will help them leave."

Ellen Fisher, assistant director of programs for the Texas Council on Family Violence, agrees that in many instances a physician's initial reaction can determine whether a woman is able to leave her violent environment.

"We know a doctor's time is very valuable," Ms Fisher said during the panel presentation. "We understand

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

FAMILY VIOLENCE UPDATE

TMA develops brochure for doctors to identify victims of violence

A brochure to help physicians identify patients who may be victims of family violence has been developed by the TMA Council on Public Health and Texas Council on Family Violence. All TMA primary care physicians will receive a copy of the brochure. Additional copies can be obtained through the TMA Public Relations Department at (800) 880-1300, ext 1390.

Domestic violence issues addressed by AMA coalition

The National Coalition of Physicians Against Family Violence has been formed by the American Medical Association to educate physicians on issues such as child abuse, sexual assault, domestic violence, and elder abuse. Information is available from the Department of Mental Health, American Medical Association, 515 N State St, Chicago, IL, 60610.

Reporting child abuse in Texas

For information on reporting child sexual abuse, physical abuse, and neglect, contact Department of Human Services, Childrens' Protective Services, 7901 Cameron Rd, Building 3, 3rd Floor, Austin, TX 78761 or call (512) 834-0034. The 24-hour number to report a suspected incidence of child abuse is (800) 252-5400.

you are not social workers, therapists, or caseworkers. But the way you initially respond to a woman who has been a victim of abuse may set the course of how she is going to respond to the whole process of leaving."

Taking an active role

Year after year, a young primary care physician and her two children withstood an onslaught of her husband's abuse. In addition to threats leveled at her children, he also told her he would halt the financial support for her medical school education and would track her down if she left the relationship.

M. Roy Schwarz, MD, senior vice president of medical education and science for the American Medical Association, knew family violence in America was a problem. But he wasn't totally convinced until he heard his colleague's story.

"Physicians alone can't turn this tide," Dr Schwarz told participants. "The AMA role is to facilitate the physicians' ability to respond, diagnose, treat, and prevent violence."

With 35% of women who go to the emergency room seeking treatment due to injuries relating to domestic violence and 37% of obstetric patients suffering abuse during pregnancy, Dr Schwarz said doctors see patients everyday in their practice who have experienced some type of injury due to domestic violence.

"You may not recognize it or ask questions or know what to do," says Dr Schwarz. "But every doctor who sees patients is seeing some form of domestic violence."

Report ranks Waco, Laredo high on child poverty level list

IT CAME AS NO SURPRISE to two Texas physicians practicing in Laredo and Waco that their communities made it on the top 20 list of cities in the United States with the highest levels of children living in poverty.

Based on US Census data compiled by the Children's Defense Fund (CDF), Laredo is second and Waco ranks 19th on the list. The report from the nonprofit organization also revealed that more than 1 in 4 children living in a city of at least 100,000 population was poor in 1989.

Both physicians agree, however, that school-based clinics may be part of the solution to the problem of providing medical care to children from low income families.

"School-based health-care clinics are the way for children to have access to health care," says Laredo pediatrician Pedro Castaneda, Jr, MD. Dr Castaneda also serves on the Texas Medical Association Committee on School Health and Children with Disabilities.

The concept of school-based clinics in Waco is already being reviewed and considered for implementation by early 1993, says Shelley Roaten, Jr, MD, program director of the McLennan County Family Practice Residency Program.

Dr Castaneda believes the CDF report does not paint the entire poverty level picture found in Laredo. Many of the 10,000 residents of the *colonias* near Laredo work for minimum wage and don't have health insurance. And most of the children do not receive medical care

Top 20 cities in United States with highest and lowest child poverty rates

Highest child poverty rates:

1. Detroit, Mich
2. **Laredo, Tex**
3. New Orleans, La
4. Flint, Mich
5. Miami, Fla
6. Hartford, Conn
7. Gary, Ind
8. Cleveland, Ohio
9. Atlanta, Ga
10. Dayton, Ohio
11. St Louis, Mo
12. Buffalo, NY
13. Rochester, NY
14. Milwaukee, Wis
15. Newark, NJ
16. Cincinnati, Ohio
17. Fresno, Calif
18. Shreveport, La
19. **Waco, Tex**
20. Macon, Ga

Lowest child poverty rates:

1. Overland Park, Kan
2. Livonia, Mich
3. Santa Clarita, Calif
4. **Plano, Tex**
5. Simi Valley, Calif
6. Irvine, Calif
7. Thousand Oaks, Calif
8. Sterling Heights, Mich
9. Fremont, Calif
10. Rancho Cucamonga, Calif
11. Sunnyvale, Calif
12. Huntington Beach, Calif
13. Scottsdale, Ariz
14. Torrance, Calif
15. Virginia Beach, Va
16. Ann Arbor, Mich
17. Arlington, Va
18. Anchorage, Alaska
19. **Arlington, Tex**
20. Sioux Falls, Idaho

Source: Children's Defense Fund *Report on Child Poverty*

until they enter school. Children who fall into this category are behind in their nutritional needs and "are not able to keep up with the other kids," says Dr Castaneda. "Down the line they start getting sick, miss class, and eventually drop out of school," he said. "The problem is access," he says. "There is one bus that comes from the *colonias* to downtown. The bus leaves at 7 am and returns at 7 pm that night. These people have to bring their children to the health department first thing in the morning, stand in line, and hope they are one of the 40 patients who will be seen that day by a physician.

"A shortage of physicians also adds to the problem," Dr Castaneda says.

A practical approach to the problem of health-care access for children in Waco is through proposed school-based clinics. "We want to take an interdisciplinary approach," says Dr Roaten. "Physicians, teachers, ministers, psychologists, and social workers will all be involved in the clinics. This is intended to benefit not only the children, but also to provide interprofessional education for the others involved."

Dr Roaten's residency program provides care to low income patients through the Family Practice Center.

"We have a lot of professionals in health and social service agencies who are aware we have a big problem," says Dr Roaten. ★

AGENDA ON AIDS

AMA physician urges AIDS education

"Our only weapon against AIDS is education," says M. Roy Schwarz, MD, senior vice president of medical education and science for the American Medical Association. Dr Schwarz, using an extensive slide presentation, was a speaker during the general session at the 1992 Fall Leadership Conference in Austin. "We have to go further in our education program toward behavior change if we really expect to be helpful in controlling this disease," Dr Schwarz added.

M. Roy Schwarz, MD

UT/TV offers AIDS education program for Texas teachers

In an effort to decrease the incidence of AIDS among teenagers, UT/TV, the educational television station at The University of Texas Health Science Center at Houston, has developed an AIDS training program. The program, created at the request of the Texas Education Agency, teaches educators how to integrate AIDS education into subjects such as math, English, social studies, and health. The lessons, tailored for grades K–12, will be available for use in all 6,000 public schools across the state. "Educators who see these kids

every day realize that students have a lot of questions about AIDS," says Susan Poag, producer of the UT/TV program. "Teachers more than anyone are aware of the urgent need for AIDS education."

Recently there has been discussion of early intervention with regard to the HIV-infected patient. What is meant by this?

An HIV-infected person will typically be asymptomatic for 6 to 10 years after infection. Therefore, the infected individual may be infecting others because they do not realize they are infected. Early intervention is meant to deal with this. The idea is to locate HIV-infected persons as soon as possible after they become infected. If this occurs, the likelihood of their unknowingly passing the virus to someone else is reduced. Recent clinical trials show that HIV-infected individuals who take antiretrovirals early in their infection have less opportunistic disease and greater longevity than those who do not take them until the destruction of their immune system is well advanced. Detecting cases early can potentially benefit both society and the infected individual. Physicians are strongly encouraged to suggest a test for HIV whenever they suspect high-risk behavior.

Richard M. Grimes, PhD, director of the AIDS Regional Education and Training Centers for Texas and Oklahoma at The University of Texas at Houston School of Public Health, will provide answers about AIDS each month in this column. For further information about this topic or any HIV topic, call the AIDS Helpline for Health Professionals at (800) 548-4659.

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Science and Education

TMA to cosponsor Women and Heart Disease Conference

TMA's Council on Scientific Affairs will join with the American Heart Association Texas Affiliate in sponsoring the third annual Women and Heart Disease Conference February 26, 1993, in Austin.

Bernadine Healy, MD, director of the National Institutes of Health in Washington, DC, has been invited to be the keynote speaker at the conference. Texas Gov Ann Richards has been invited to host the symposium. TMA's Board of Trustees approved the Council on Scientific Affairs' recommendation from its meeting at the TMA Fall Leadership Conference in September to cosponsor the event.

"The council believes that cosponsorship of the conference will demonstrate TMA's continuing commitment to women's health."

"The council believes that cosponsorship of the conference will demonstrate TMA's continuing commitment to women's health and build on the theme of its 1992 annual session symposium, 'A New Look at Women's Health Issues,'" said John W. Burnside, MD, council chairman.

The conference will be held in conjunction with the TMA Winter Leadership Conference in Austin. Dr Healy has also been invited to be the keynote speaker for the leadership conference and to meet with Texas Commissioner of Health David R. Smith, MD, to discuss public health issues.

The Women and Heart Disease Conference, the largest of its kind in the United States, hosted 650 participants in its first year in 1990. Attendance topped 1,000 in 1991, and that many or more are expected at the 1993 meeting, scheduled for the new Austin Convention Center.

In other business, the Council on Scientific Affairs:

- Heard a proposal from Anthony Lucci, MD, that TMA cosponsor with St Joseph's Hospital of Houston a CME symposium entitled Fetoplacental Pathology and Assessment of the Brain-Damaged Infant. Dr Lucci noted that the program was initiated by the Council on Scientific Affairs in 1989 due to concern about the lack of obstetrical services in 92 Texas counties because of soaring malpractice rates. Since the series of sumposia began, Dr Lucci noted, the number of nonmeritorious claims has dropped significantly. The Board of Trustees approved the council's recommendation that TMA cosponsor the symposium.
- Reviewed a resolution referred from the House of Delegates opposing the use of human fetal tissue in research in that it may increase the incidence of abortion and may lead to trafficking in fetal parts. Following a discussion, the council recommended a substitute resolution stating that the TMA support the use of fetal tissue for research with the application of the same scientific and ethical standards that apply to other forms of human tissue research. The substitute resolution will be considered by the House of Delegates at its November 19–21 meeting.
- Reviewed the issue of whether autologous bone marrow transplant for treatment of breast cancer should be considered experimental or accepted medical practice. Many insurers are denying payment for the procedure on the grounds that it is unproven, resulting in the postponement of clinical trials. The council decided that further study was needed.
- Proposed that TMA join with the Texas Society of Biomedical Research in honoring Congressman Charles W. Stenholm (D-Tex) at the 1993 Annual Session for his authorship of the Animal Enterprise Protection Act of 1992 passed during this session of Congress. The act extends federal protection to agricultural and animal research facilities from "animal enterprise terrorism."

Program seeks to find, bring rural scholars back home

It may be tough to keep 'em down on the farm after they've seen Paris (or even Lubbock, for that matter), but a new program by the Texas Center for Rural Health Initiatives is designed to recognize academic achievements by students from rural areas studying to go into health professions and to encourage them to return to practice in a rural area.

The Texas Outstanding Rural Scholar Recognition Program will reward individuals seeking training in a health career who plan to work in a rural Texas community and will include a student loan forgiveness

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

MEDICINE IN TEXAS: NEWS FROM AROUND THE STATE

New M.D. Anderson program to focus on brain tumors

The University of Texas M.D. Anderson Cancer Center, Houston — A $2.34 million National Cancer Institute grant will form the nucleus of the new Brain Tumor Center, a multidisciplinary collaboration towards the elimination of central nervous system tumors as a significant health problem. The center will be directed by Victor A. Levin, MD, who is chairman of the department of neuro-oncology. The center will have 34 faculty members on staff. One of its first studies will be of the new drug, eflornithine, one of only two drugs with FDA approval to treat brain tumors. The center also plans to expand a brain tumor tissue bank and refine the use of lasers in brain tumor surgery.

Scott and White celebrates 100 years of surgery

Scott and White Memorial Hospital and Clinic, Temple — Internationally known surgeons from across the US served as featured speakers September 10–12, 1992, as Scott and White Memorial Hospital celebrated the centennial of surgery in Temple. The celebration consisted of lectures, an informal historical program, tours of the Scott and White Log Cabin Museum, which served as Dr Scott's private retreat from the 1920s until his death in 1940, and a reenactment of a 1902 photograph of Dr Scott and Dr White in a horse-drawn buggy with the grandsons of both men playing their parts in period costumes.

Science teachers get update on cutting edge of research

The University of Texas Southwestern Medical Center, Dallas — Science teachers in the Dallas-Fort Worth area were STARS for a day September 19, as they attended a symposium for secondary school biological science teachers, sponsored by the Science Teacher Access to Resources at Southwestern (STARS) Program. The theme of this year's symposium was developmental biology, from fundamentals to cutting-edge research. UT Southwestern faculty discussed how cells become different during development, how the architecture of an embryo is determined, and how membrane receptors control pigment and germ-cell development in mouse and man. This is the second year Southwestern has offered symposia to science teachers, said Curtis Chubb, MD, associate professor of cell biology and neuroscience and STARS coordinator. Three more symposia are planned during this academic year.

New center promotes study of brain, nervous system

The University of Texas Health Science Center, Houston — Scientists trying to find treatments for epilepsy, Alzheimer's disease, Parkinson's disease, drug abuse, and other diseases and disorders of the brain and nervous system will use the new Neuroscience Research Center. The center, according to its founders, will provide an "umbrella" under which researchers with common interests may share information and collaborate on projects. Initial plans for the center include establishing interdepartmental seminars on neuroscience topics; initiating a distinguished lecture series to bring neuroscientists from other parts of the country to UT-Houston; publishing a newsletter about ongoing research at the center; and establishing interdepartmental graduate and postdoctoral programs in the neurosciences. More than 100 neuroscientists work at UTHSC-Houston.

Information for this column comes from a variety of sources, including academic institutions, state and federal agencies, and private institutions. We welcome submission of items of interest. Send them to Texas Medicine, *Science and Education Editor, 401 W 15th St, Austin, TX 78701.*

program for those students chosen for the program.

Under the program, a rural community or an organization in a rural community sponsors a student in a health-care field. The sponsor agrees to contribute financial support for the student's education in return for the student's assurance that he or she will practice in that community upon graduation.

One such student will be chosen each year as an Outstanding Rural Scholar. Those chosen will be eligible for a loan forgiveness program, which will be a cooperative arrangement between the state of Texas and local community sponsors. Participating communities must be located in a Texas county defined as nonmetropolitan by the Census Bureau.

Nominations for Outstanding Rural Scholar are accepted in December. For more information about the program, contact the Texas Center for Rural Health Initiatives, PO Drawer 1708, Austin, TX 78767-1708, or call (512) 479-8891.

History of Medicine Museum seeks WWI and WWII artifacts

TWICE IN THIS CENTURY, THE world has been at war with itself, and physicians were called upon to heal the wounded. The TMA History of Medicine Museum is seeking medical artifacts from World War I and World War II for an exhibit on military medicine from those two wars.

"We're interested in medical manuals, medical instruments, uniforms, medals, ribbons, patient care notes — anything that would show the type of medicine practiced dur-

ing those two wars," said Susan Brock, director of the TMA Library and museum coordinator. "We are particularly interested in photographs depicting medical care, both at the front lines and in the evacuation trains and hospitals in the rear areas."

She also wants artifacts that demonstrate women's roles as physicians and nurses in the war effort.

The museum is seeking donations of artifacts or will accept them on loan, Ms Brock said. She asks that interested individuals contact her before shipping any material to the museum.

For more information or to donate items for the early-1993 exhibit, contact Ms Brock at (800) 880-1300 or (512) 370-1540.

UT Health Science Center-San Antonio nets $15.8 million in grants

THE NATIONAL INSTITUTES of Health has awarded $15.8 million in federal grant funds to three major research programs — diabetes, breast cancer, and aging — at The University of Texas Health Science Center in San Antonio.

The National Cancer Institute has awarded $8 million for a 5-year "program project," building on 15 years' work at the health science center, aimed at identifying prognostic factors for disease and improving treatment and survival rates.

Gary C. Chamness, PhD, professor of medicine, is the principal investigator. Dr Chamness will be continuing the work of William McGuire, MD, the internationally known breast cancer researcher who died earlier this year while scuba diving in Mexico.

The National Institute on Aging has awarded $5.4 million for a 5-year continuation of work on the physiological basis of aging. Researchers will study the effects of free radicals as well as diet restriction and other factors of the aging process.

Byung P. Yu, PhD, professor of physiology, is principal investigator.

The National Heart, Lung and Blood Institute has awarded $2.5 million for work to understand and to control diabetes and cardiovascular diseases in Mexican- and Anglo-Americans. The work builds on the San Antonio Heart Study, which has already revealed ethnic, diet, and lifestyle factors affecting the incidence of diabetes in various populations.

Michael P. Stern, MD, professor of medicine, is principal investigator. ★

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The Texas Society of Internal Medicine and the **American College of Physicians, Texas Academy Chapter** will meet in conjunction this year in Austin.

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Legislative Affairs

TMA supports task force recommendations

TEXAS MEDICAL ASSOCIATION has given "thumbs up" to the bulk of health-care reform proposals produced by a special governor's task force. At the same time, serious concerns have been expressed about a number of the panel's proposals, including the controversial recommendation to move toward a single-payor system.

In written comments submitted in late September, TMA endorsed numerous recommendations included in the draft report of the Texas Health Policy Task Force, including proposals to expand Medicaid, carry out small-market insurance reforms, and fund a statewide trauma care system.

"It is painfully clear that the status quo is unacceptable and further inaction indefensible," TMA President William G. Gamel, MD, said in a letter accompanying TMA's written comments. "We strongly support your efforts and the vast majority of the draft recommendations now under consideration."

Many of those recommendations are based largely on the five-part reform plan developed in 1991 by TMA's own ad hoc committee on health-care reform.

TMA's comments were drafted following presentation of the draft task force report, along with comments solicited from numerous specialty societies and TMA councils and committees, to the Council on Legislation and the special Health Policy Advisory Panel during the TMA Fall Leadership Conference in September.

Despite the vast media attention given the single-payor proposal, the task force labeled its recommendation for improving maternal and child health care as the top priority. That recommendation calls for creation of a Texas Children's Health Plan that would make high quality, comprehensive health care available to all children 18 years of age and younger and to all pregnant women, regardless of income. It is estimated the program would require more than $4 billion in new spending, but 65% of that could come from federal matching funds.

The task force says extended public benefits to all income groups would eliminate the need for families to purchase private insurance coverage for children, reduce uncompensated care, and cut employers' health insurance costs. However, the task force also recommends that participation in the plan be voluntary.

"In general, TMA supports these recommendations subject to review of the administrative structure of the health plan," TMA said in its comments. "Although, certain confusion still remains over what constitutes voluntary participation in the program."

Other major recommendations supported by TMA include proposals to strengthen the existing private insurance structure, including beefing up financial reserve requirements for health coverage plans, enabling small groups to pool resources to purchase health coverage, standardizing treatment of preexisting conditions by regulated health plans, imposing limits on premium rate increases, and more. Again, many of these proposals were contained in TMA's ad hoc committee report.

TMA also endorsed recommendations to implement and fund the statewide trauma system authorized under the Omnibus Health Care Rescue Act of 1989, as well as calls for further study of medical liability issues.

While TMA backs many of the proposals that can be accomplished in the short term, the association strongly took issue with the task force's recommendation that a single-payor system is the "optimal long-term direction" for health care in Texas.

"To date, no state in the US has successfully implemented, or even attempted to implement, a single-payor system," TMA wrote. "In Canada, where the single-payor notion is drawn from, provincial authorities are rethinking the wisdom of a single payor since vast administrative savings have not been achieved."

TMA also took issue with proposals to expand the role of nonphysician providers and to ensure "fair and equitable reimbursement" for all providers.

TMA said it is prepared to work with nonphysician providers and others to eliminate barriers that prohibit those providers from fully participating in the team concept of health-care delivery. However, the association "has serious concern for patient welfare" over proposals for independent practice for nonphysician providers.

TMA's comments also cast doubts on whether paying nonphysician providers at the same rates as physicians would prompt them to practice in areas where physicians currently do not practice. Instead, it may adversely affect recruitment or retention of physicians in rural or underserved areas, the comments contended.

The task force met September 29 and 30 to review public comments and approve its final report. That report was to be issued to Gov Ann Richards on November 1.

Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs section of* Texas Medicine.

TASK FORCE RECOMMENDATIONS

The following is a comparison of the major recommendations contained in the draft report of the Texas Health Policy Task Force and Texas Medical Association positions.

Task Force Recommendation	TMA Position
Development of a statewide system for financing and ensuring access to high quality, comprehensive health care for all children and all pregnant women.	TMA supports recommendation subject to review of the administrative structure. TMA's Ad Hoc Committee on Financing and Availability of Health Insurance proposed expansion of Medicaid to all children living below the federal poverty level and to all pregnant women below 185% of poverty.
Expansion of Medicaid eligibility to other populations, as well as expansion of services covered by Medicaid.	TMA recommended similar expansions in the ad hoc committee report, including eligibility for young adults between ages 18 and 20, provision of earlier prenatal care, and use of primary and preventive care services.
Enactment of private insurance reform including strengthening financial reserve requirements for health plans, enabling small groups to pool resources for purchase of coverage, standardizing treatment of preexisting conditions, and imposing limits on premium increases.	Most of these recommendations are consistent with the ad hoc committee recommendations or TMA policy.
Removal of barriers to allow nonphysician, licensed providers to participate to the full limits of their education and skills; fair and equitable reimbursement of all health-care providers.	TMA is prepared to work with nonphysician practitioner (NPP) groups, elected officials, and others to identify and eliminate those barriers that prohibit NPPs from fully participating in the team concept of health-care delivery. However TMA has serious concerns for patient welfare over the independent practice (ie, no linkages to physician) proposal for NPPs. TMA believes nonphysician providers should be paid as a percentage of physician services based on qualitative and quantitative differences in their education.
Development of incentives to encourage providers to accept Medicare and Medicaid patients.	TMA believes recent positive changes in Medicaid are promoting participation among member physicians. The association also believes appropriate funding should be approved to make physician reimbursement fair and equitable for all medical specialties.
Prohibition against providers referring patients to facilities in which they hold a financial interest, with waivers for areas of need.	TMA supports full disclosure of any interest in a facility to which a physician refers patients and tough investment restrictions.
Full funding for the statewide trauma system authorized in House Bill 18 in 1989.	TMA lobbied to authorize the trauma system in 1989 and supports its funding.
Enactment of cost containment measures, including negotiated rates, expenditure limits, standardization of benefits, and streamlining management to reduce rates.	While TMA believes rate negotiations should be studied, it maintains expenditure limits will lead to health-care rationing. TMA does support standardization of utilization review systems.
Creation of a single-payor system for Texas at some point in the future.	TMA does not believe there are valid and reliable data to show a single-payor system would produce administrative savings in the health-care system.

US Rep J.J. "Jake" Pickle (D-Austin) emphasizes a point during an address on congressional health-care debate at TMA's Fall Leadership Conference. "The cost of medicine and health are becoming the most commanding problem in the federal budget," he said.

Council recommends gun legislation

A BAN ON PRIVATE OWNERSHIP of assault weapons and destruction of firearms seized in criminal cases are parts of a gun control policy the Texas Medical Association Council on Legislation will ask the House of Delegates to approve in November.

The council recommended an eight-point gun control policy to the House of Delegates in lieu of a Dallas County Medical Society resolution calling for "effective gun control." That resolution was referred to the council in May by the House.

In addition to the provisions on assault weapons and destruction of guns used in crimes, the council's recommendations call for:

- Adding firearms education to comprehensive school health education.
- Urging the American Medical Association House of Delegates to support improved public education and efforts to decrease depiction of violence on television.
- Requiring weapons design modifications to make handguns inoperable by children.
- Encouraging physicians to add firearm injury prevention questions when taking medical histories and to identify high-risk homes and patients to help alleviate adolescent suicides, accidents among children, and homicides in the course of family disputes.
- Requiring a waiting period before purchase of a firearm.
- Banning the carrying of handguns in public. This already is law in Texas.

Many of the points recommended by the Council on Legislation were part of a report on firearm injury and gun control prepared by the Council on Public Health.

At a September 18 meeting of a Council on Legislation subcommittee that reviewed the Dallas County resolution, A.H. "Buddy" Giesecke, MD, Dallas, said physicians must get involved in firearm issues.

"The United States leads the world in murders and Texas leads the nation," Dr Giesecke said. "I think we've achieved a threshold where we should be concerned and we should take a position."

'Sunset' advisory panel appointed

TMA PRESIDENT WILLIAM G. Gamel, MD, has appointed a special committee to monitor "sunset" review of the Texas State Board of Medical Examiners and nearly 20 other health professional licensing agencies.

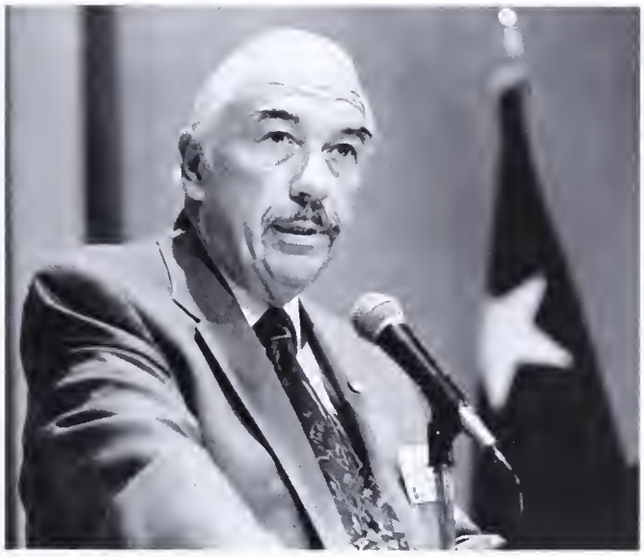
The TMA Ad Hoc Advisory Committee on the Texas State Board of Medical Examiners, chaired by former TMA President Wm. Gordon McGee, MD, El Paso, is serving much the same role as did the Health Policy Advisory Panel appointed by Dr Gamel to monitor actions of the Texas Health Policy Task Force.

The committee was charged with identifying and studying issues pertaining to the medical board and the Medical Practice Act. It also is reviewing issues pending before the state Sunset Commission.

The panel includes both physicians and attorneys who have experience practicing before the medical board. In addition to Dr McGee, members include Merle Delmer, MD, San Antonio; Harold Skaggs Jr, MD, Austin; John Brenner, DO, Fort Worth; and D. Clifford Burross, MD, Wichita Falls. Attorneys on the committee include Dan Bishop, JD, of the Austin law firm Scott Douglas & Luton; Jerry Bell, JD, of Fulbright Jaworski, Houston; and Nancy Strickland, JD, of Harris Methodist Systems, Fort Worth.

Sunset Commission staff already have begun their review of the health licensing agencies. The full commission is scheduled to issue recommendations on whether to continue, discontinue, or modify each of the agencies by the time the 73rd Legislature convenes in January.

Lawmaker predicts tough session for physicians



State Sen Chet Brooks (D-Pasadena) discusses health-care reform recommendations of the Texas Health Policy Task Force during a panel discussion on upcoming legislative issues at the TMA Fall Leadership Conference.

THE 1993 LEGISLATIVE session may prove to be the most challenging one the medical profession has ever faced. That's the forecast state Rep Jack Vowell (R-El Paso) delivered to physicians who attended Texas Medical Association's Fall Leadership Conference on September 19.

"We'll (the Legislature) vote on more health-care issues than have ever been thought of in the last decade," Representative Vowell said during a panel discussion on medical and health issues facing the 73rd Legislature.

Among issues that will be at the forefront of the health-care debate are the recommendations of the Texas Health Policy Task Force, sunset of the Texas State Board of Medical Examiners and other health licensing agencies, and reorganization of health and human services agencies to provide more cost-effective delivery of services, he said.

Representative Vowell warned physicians that they will have to take the lead on many issues, such as scope of practice for allied health professionals and containing spiraling health-care costs.

He said physicians must give careful consideration to where they want health care to go rather than trying to block change.

"If you sit back and say 'I like things the way they used to be, I want to go back to the good old days,' I can tell you you'll be swept away by events," he said.

State Sen Chet Brooks, a Pasadena Democrat who also was on the panel, advised physicians not to let debate over a single-payor health-care system overshadow other recommendations in the Health Policy Task Force report.

"We must not let that fuss over the system of payment destroy or overshadow all of the other very, very significant recommendations that are carried forward," he said.

Senator Brooks said he does not want to see Texas go to a single government system for providing all health care, something he described as "the worst of all worlds.

"If we can take the public dollars we're spending and have it mesh in some way with the private dollars . . . then we can have universal access," Senator Brooks said. "But I don't want to see us lose the viability and the valuable assets that are in each of those systems." ★

State Rep Jack Vowell (R-El Paso) warns participants at TMA's Fall Leadership Conference that health issues could dominate the 1993 session of the Texas Legislature.

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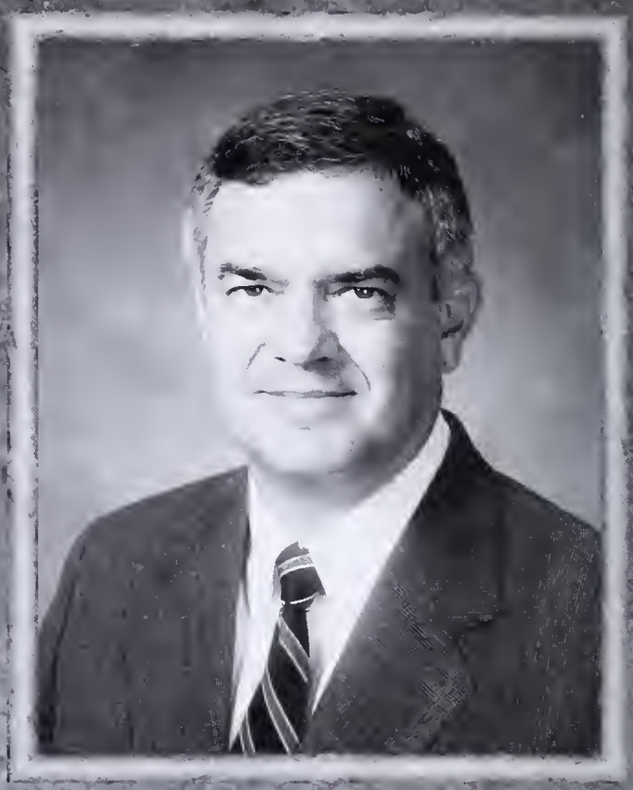

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S C O P E

THE TABLES are turning on the state's "doctor cops." ¶ Responsible for ensuring that bad doctors are kept out of the profession, the Texas State Board of Medical Examiners routinely conducts investigations as part of its job to license and discipline physicians. ¶ But now the board itself is under investigation as part of the Texas Legislature's "sunset" review process, the mechanism that automatically terminates every state agency on a 12-year staggered-start cycle and forces re-justification of their existence. One of 20 health licensing boards — including dentists, chiropractors, nurses, and pharmacists — being reviewed in 1993, the board and the Medical Practice Act under which it operates face scrutiny by 150 state representatives and 31 state senators. ¶ Since the sunset process typically grants every suggestion — however meritorious, misguided, or deeply disturbed — a full airing, the board is likely to get a dose of political medicine along with its legislative physical. Some, though not all, of the criticism aimed at the board will be politically motivated and legislators will have to sift through testimony, research, and orchestrated attacks. ¶ Despite its inherent risks, however, the sunset process also provides opportunities to enhance the medical board's strengths and address its weaknesses. ¶ This article is an in-depth look at the Texas State Board of Medical Examiners as it heads into sunset.

By *Ken Ortolon, Legislative Affairs Editor*

THERE'S A WISE, old saying: You can't please everybody.

But if you're the Texas State Board of Medical Examiners, it's nigh on impossible to please anybody.

The board that holds life or death power over the careers of every licensed physician in Texas is preordained to be criticized by at least three quarters of the people it comes into contact with: doctors, lawyers, lawmakers, consumer advocates, even some board members. Depending on whom you ask, the board either is too lax in drumming bad doctors out of the profession, too aggressive, or so stingy with licenses that it prevents good doctors from coming to Texas.

Mishaps and horror stories do occur and they make excellent fodder for the board's detractors. According to a recent *Houston Chronicle* series about the board, at least 19 convicted felons are practicing medicine in Texas. Physicians whose licenses are on probationary status — many because of alcohol and drug abuse — practice with little or no supervision because of a shortage of probation officers. And, incompetent physicians have practiced for months, even years, after complaints were filed because of the lengthy investigative and disciplinary processes or court action blocking revocation of their licenses.

These and other problems will be probed by the Texas Legislature during "sunset" review of the agency and the Medical Practice Act in 1993. Preliminary review of the board by the Sunset Commission staff is under way. The debate promises to be contentious.

But the single most important thing to understand about the sunset process is that it is, by definition, political.

"Make no mistake about it: The legislative examination of the Texas State Board of Medical Examiners is politically driven," says Kim Ross, Texas Medical Association director of public affairs. "Reforms obviously are needed and most have already been recommended by the Texas Medical Association. Nonetheless, it will be difficult to separate political exploitation from the legitimate scrutiny of the board."

The board does a creditable job of policing the medical profession with an inadequate budget and overworked staff, he adds. "If you look at where the board was several years ago and where they are now, there's a marked improvement. They've created a clinical investigative staff. They've greatly improved complaint processing. And they've enhanced consumer access to the board."

Even some board critics concede that the public can be confident that few incompetent physicians are practicing in Texas.

"Ninety-nine percent of the doctors are doing a great job. Their motivation is correct and their practice of medicine is good and they're dedicated to their patients," says Houston physician C. Richard Stasney, MD, one board member who has been openly critical of the board's past performance. "It's just a small percentage that's really giving us a black eye."

Board affects every Texas physician

PROTECTING THE PUBLIC against that "small percentage" and against the practice of medicine by nonphysicians is exactly what the Medical Practice Act and the board were set up to do. TMA President William G. Gamel, MD, Austin, has called the Texas law one of the best medical practice acts in the nation because of its strength.

"For all of the problems in medicine that we have in Texas, we still have one of the better practice environments in the country in terms of what state statutes can control," he says. "If you look at what is *not* in this state that is plaguing doctors in other states, you realize that we are the fire wall. Other states have already witnessed massive incursions into medical practice by nonphysicians. Physicians else-

Texas State Board of Medical Examiners

The Texas State Board of Medical Examiners is a 15-member board made up of nine medical doctors, three osteopaths, and three public members. The members are appointed by the governor for 6-year terms. Officers are elected by the board members.

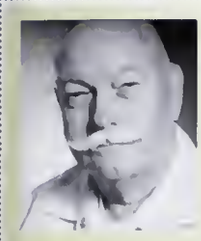
Current members of the board include:

Gilberto Aguirre, MD
SAN ANTONIO
Specialty: *Ophthalmology*
Term: *May 1989–April 1995*
Education: *The University of Texas Medical Branch at Galveston*

Betty Lou "Penny" Angelo
MIDLAND
Public Member
Term: *May 1989–April 1995*
Education: *The University of Texas at Austin*

George S. Bayoud, MD
DALLAS
Specialty: *General Surgery*
Term: *January 1988–April 1993*
Education: *American University of Beirut*

Marianne Beard, DO
ARLINGTON
Specialty: *General Practice*
Term: *September 1991–April 1997*
Education: *Texas College of Osteopathic Medicine*



JOHN H. BOYD, DO (SECRETARY-TREASURER)
EDEN
Specialty: *General Practice*
Term: *January 1988– April 1993*
Education: *Kirksville College of Osteopathy and Surgery, Kirksville, Missouri*

BARBARA JUNE COE (VICE PRESIDENT)
DALLAS
Public Member
Term: *January 1988–April 1993*
Education: *The University of Texas at Austin and University of Pennsylvania*

WILLIAM H. FLEMING III, MD (PRESIDENT)
SUGAR LAND
Specialty: *Neurology*
Term: *September 1990–April 1995*
Education: *St Louis University School of Medicine*

CATALINA ESPERANZA GARCIA, MD
DALLAS
Specialty: *Anesthesiology*
Term: *September 1991–April 1997*
Education: *The University of Texas Southwestern Medical School, Dallas*

CYNTHIA "CINDY" JENKINS
STOWELL
Public Member
Term: *January 1984–April 1997*
Education: *Lamar University*

Continued on p 40.

where have lost the battle over the corporate practice of medicine and are facing corporations that can hire and fire them, insurance companies that can drive them out of town, and managed care situations that they cannot live with."

Texas physicians also are envied because of the superior protection of hospital peer review provided by the Medical Practice Act.

"If a medical staff member complains about a physician who is ultimately removed from the staff through the proper process, that staff member is immune to the inevitable lawsuit thanks to the amendments to the Medical Practice Act that we gained in 1987," says Mr Ross.

James Winn, MD, executive director of the Federation of State Medical Boards, agrees that both the Texas law and the board are sound.

"The board is very close to what the federation advocates for all medical boards as far as structure — it has public members, a good solid medical practice act, and it's constituted very well, I think," he says.

The act grants the board considerable power to carry out its licensing and disciplinary functions. It now licenses nearly 1,200 physicians annually by examination and nearly as many by reciprocal endorsement from other states. The board staff also opens about 1,800 investigations annually and currently is conducting more than 1,200 ongoing investigations.

If a physician constitutes an imminent threat to the public, the board's executive committee can suspend the doctor's license immediately without a hearing, a provision TMA helped put into the Medical Practice Act as part of the 1987 amendments.

Registration of acupuncturists and physician assistants adds to the board's workload.

The bottom line is, if you practice medicine in Texas or if you plan to practice here upon completion of medical school, you *will* come into contact with the board. For most physicians and medical school graduates seeking a license in Texas, that contact is routine. But for physicians who get into trouble, contact with the board can be unpleasant, time-consuming, and expensive.

An Austin attorney who frequently practices before the board says no physician can afford to assume he or she will never hear from the board again once his or her medical license is issued.

"Any physician who feels he's not going to hear from the Board of Medical Examiners is naive," he says.

PHILOSOPHIES OF DISCIPLINE DIVIDE BOARD

IN SPITE OF ITS BROAD powers, or perhaps because of them, board members are divided about what the board's primary role is. Personalities and strongly held attitudes of some board members fuel the dissension. To some members, disciplining physicians is the board's primary purpose. Others place far more emphasis on rehabilitating physicians who have had problems.

Cindy Jenkins, a nonphysician board member from Stowell, thinks discipline should be the vast majority of the board's work. She wants the board to take more of an activist stance in policing the profession, and she faults both physician members of the board and the board's staff for not moving in that direction.

"I think the doctors on the board frequently put themselves in the physician's place, while I put myself in the injured patient's place and look at it from a whole different angle," she says.

She also complains that the staff, in the past, has felt their job was more to "get along" with physicians who have faced disciplinary action than to ensure they are practicing good medicine.

Board member Gilberto Aguirre, MD, of San Antonio, strongly disagrees with Ms Jenkins' approach.

"Some of the board members' attitudes, in my opinion, are that the doctor is considered guilty until

proven innocent," he says. "Some board members believe we should have a quota of disciplinary actions. I say that's a bunch of bunk. You have to look at each individual case on its own merits and let the chips fall where they may."

The idea of quotas most likely was spawned by Sidney Wolfe, MD, who heads the Health Research Group for the Washington, DC-based Public Citizen, a consumer advocacy group founded by Ralph Nader. Dr Wolfe has said state medical boards should discipline about 10% of their licensees each year. In Texas, where there are more than 40,000 licensed physicians, that would come to more than 4,000. Dr Wolfe frequently has been highly critical of the Texas board.

In 1989, he ranked the board 48th among all state boards in actions taken against physicians. His report criticized the board for failing to raise licensing fees to adequately finance its investigative activities. However, revenue raised from licensing fees does not stay in the board's coffers but goes to the state's general revenue. The legislature appropriates only a fraction of it back to the board.

While Dr Stasney has been vocal in his criticism that the board is too lenient with many physicians, he does not agree with Public Citizen's assessment of the board's performance.

"I'm a vocal critic of the board, but those people were totally off base," he says.

Kim Ross also bristles at the suggestion that quotas are needed.

"They seem to think that physicians do not deserve the same legal rights as a violent criminal," he says. "A scalp-hunting mentality runs totally contrary to our system of justice. The system gives proper weight to identification of problems and rehabilitation, not just crime and punishment. You would think a vaunted liberal organization like Public Citizen would appreciate a basic principle such as the presumption of innocence."

Texas ranks right around the middle of the pack in disciplinary actions per 1,000 physicians based on ratings released annually by the Federation of State Medical Boards.

But Mr Ross points out that some other states' medical boards rate higher because they count non-license renewals or minor technical violations as disciplinary actions, padding their scores.

Despite the concern over physician discipline, Homer Goehrs, MD, the board's executive director, says licensing may well be a more important activity in ensuring Texas has quality physicians. By being extremely prudent about the physicians it licenses, the board hopes to avoid having to discipline them in the future.

Licensing can be straightforward

There are two basic ways to get a medical license in Texas — by examination or by reciprocal endorsement from another state.

Licensure by examination is the most direct approach and it usually presents few administrative problems for the future physician. All medical school graduates who sit for the Texas licensing exam take the FLEX — the Federation Licensing Examination — which was developed by the Federation of State Medical Boards. That likely will change soon because a new test — called the United States Medical Licensing Examination — is expected to replace the FLEX throughout the nation. About 1,200 medical graduates sit for the exam in Texas each year, including between 800 and 900 from Texas medical schools and 300 out-of-state or foreign graduates.

The process is pretty simple: If you pass the FLEX and the Texas medical jurisprudence examination, you get your license. If you fail, you don't. The only other snag usually involves criminal convictions or alcohol or drug abuse that students faced prior to or during medical school.

Graduates with these types of histories usually must convince the board's examination committee they

Alfred Raymond Johnson, DO
DALLAS
Specialty: *Internal Medicine*
Term: *January 1988–April 1993*
Education: *The University of Health Sciences, Kansas City, Missouri*

Regina F. Kyles, MD
SEABROOK
Specialty: *Internal Medicine*
Term: *August 1992–April 1995*
Education: *The University of Texas Medical Branch at Galveston*

John Lewis, MD
HOUSTON
Specialty: *Cardiovascular Diseases*
Term: *September 1991–April 1997*
Education: *Baylor College of Medicine, Houston*

Luis M. Rios, MD
MCALLEN
Specialty: *Plastic Surgery* Term: *May 1989–April 1995*
Education: *National University of Mexico, Mexico City*

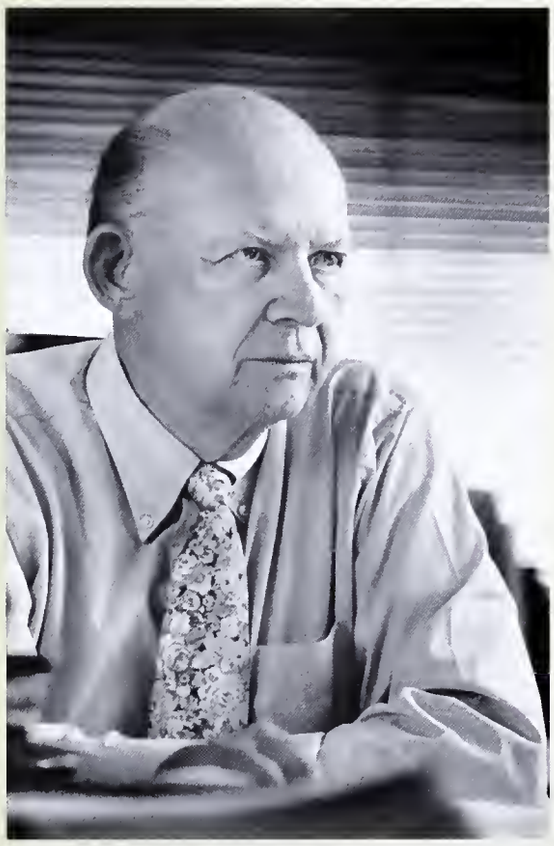
Ratna Solomon, MD
DALLAS
Specialty: *Obstetrics and Gynecology*
Term: *January 1988–April 1993*
Education: *Christian Medical College, Ludhiana, India*

C. Richard Stasney, MD
HOUSTON
Specialty: *Otorhinolaryngology*
Term: *January 1988–April 1993*
Education: *Baylor College of Medicine, Houston*

The physician at the center of the controversy

When Homer Goehrs, MD, assumed the position of executive director of the Texas State Board of Medical Examiners in April 1990, he immediately found himself on the hot seat.

Almost instantly he was criticized by a state senator who did not like the way a particular case was being handled by the board staff. He also faced conflicts from some board members, particularly Cindy Jenkins, who doesn't think Dr Goehrs exhibits the kind of activism the board and its staff should display.



"I think Dr Goehrs thinks his position is to cover up the bad the board's doing and nothing else," she says. "He and I don't have the same idea of what the agency exists for."

Kim Ross, TMA's director of public affairs, says much of that criticism is unfounded. "Dr Goehrs was handed the keys to the Titanic," he says. "When you come aboard a ship that's about to go through sunset, they're going to shoot the captain whether he deserves it or not."

Despite the early criticism, Dr Goehrs quietly goes about the business of running what has been described as the most visible licensing agency in the state. He admits there are more pressures on the executive director than he anticipated when he took the job, but he seems to accept them now as part of the territory.

"It's difficult to be all things to all people, and that's what this position does," he says. "It's a high visibility agency as far as state government is concerned because we deal with practitioners who affect people's lives and health. So we're more vulnerable to criticism than, say, is the State Board of Accountancy."

Dr Goehrs came to the board after a 40-year career as a rheumatologist. A graduate of Baylor College of Medicine, he trained at Baltimore City Hospital in Maryland and the Mayo Clinic in Minnesota. In 1958, he and three other physicians founded the Austin Diagnostic Clinic, which has grown to more than 100 physicians.

His service to organized medicine and the Austin community also is extensive. Dr Goehrs was president of the Texas Rheumatism Association, the Travis County Medical Society, and the Travis County Medical Blood Bank. He also has been active in the Texas Medical Association, American Medical Association, and National Society of Clinical Rheumatologists.

Physicians and others in Austin who know Dr Goehrs well have nothing but praise for him.

"Dr Goehrs is a doctor's doctor," says John Kemp, former executive director of the Travis County Medical Society. "When other doctors go to you, you know they respect you very much. He is extremely well regarded as a physician and a person."

Retired Austin pediatrician Clift Price, MD, says he recommended Dr Goehrs when former executive director G.V. Brindley, MD, was planning to retire.

"I've been very impressed with what he is trying to do at the Board of Medical Examiners," Dr Price says. "Homer has not been bothered by people barking at him. He's done a remarkable job with very limited resources."

Dr Goehrs also has his defenders on the board. Board member Penny Angelo of Midland is among them.

"I think he's streamlined a lot of things," she says. "He doesn't gloss over things. He's very succinct in telling Senate and House committees what our problems are and I think he's gone to bat for us as far as our finances are concerned over and over."

Dr Goehrs says there have been many accomplishments in his 2 years at the board. The computer system was upgraded, rules governing physician assistants were revised, the acupuncture advisory committee was reactivated, and relationships with the legislature were rebuilt. Also, he points to the improved quality of the board's legal staff and the reduced time it takes to investigate complaints.

However, he gives his staff most of the credit for the changes. "It's the staff and me," he says. "I didn't do any of this by myself."

have adequately addressed the problems before getting their license. Ms Jenkins, who chairs that committee, says as many as four to eight such applicants appear at each board meeting. Most eventually are allowed to sit for the exam and do get their license, she says.

"If they've truly cleaned up, then we don't have anything but 5- or 6-year-old information and the courts just aren't going to uphold us in keeping these people from being licensed," she says. "Maybe they'll make good doctors, but I've seen sev-

New licensing exam creates problems for medical schools

A new examination for physicians that almost certainly will become the standard for licensure in Texas presents big challenges for Texas medical schools. The exam is an attempt to standardize an array of examinations into one pathway for licensure.

James Rohack, MD, College Station cardiologist and chair of TMA's Council on Medical Education, says the new test — the United States Medical Licensing Examination (USMLE) — is causing medical schools to fine-tune their curriculum.

"For the first time in Texas we're going to be testing students as they start their education," Dr Rohack says. The purpose of Step 1 of the USMLE is not to measure what students should be taught but rather what they should have learned in the basic sciences.

The new exam replaces the FLEX, or Federation Licensing Examination. Homer Goehrs, MD, executive director of the State Board of Medical Examiners, says the board will make a formal decision this fall on whether to use the USMLE as the state's licensing exam but that decision will be academic because the FLEX will no longer be offered after June 1994.

The problem for medical students, Dr Rohack says, is that the USMLE is a three-part exam. The first part is taken at the end of the second year of medical school, the second part at the end of the fourth year, and the third part at the end of the first year of postgraduate training.

"What does the medical school do with a student who flunks the first part of the exam?" Dr Rohack asks. "Do you hold that person back or do you let him proceed?"

He predicts that different medical schools will take different approaches. Some will use the first part of the USMLE as a barrier exam. Students who fail will not be allowed to advance until they pass the test. Other schools will let students continue their education but require them to retake the exam. The National Board of Medical Examiners recommends that Step 1 *not* be used as the sole determinant of promotion to the third year.

(In June, all Texas medical schools implemented Step 1 of the USMLE. Currently, none of the schools are using the USMLE as a barrier to advancement.)

Regardless of whether schools use the exam as a barrier, Dr Rohack says they must refocus their curriculum to ensure they are teaching material that will be on each part of the exam. To that extent, licensure will drive the curriculum, he says.

eral instances where they relapsed."

During an examinations committee meeting in August, the committee delayed licensure for two medical school graduates with long histories of drug abuse. However, it did not tell either physician they never would be licensed. Instead, the committee told one to come back when he had a longer history of sobriety; the other must provide better documentation of his ongoing counseling.

"The medical schools do not ask questions on their entrance forms about prior drug use," Ms Jenkins says. "It puts the burden on the board to throw $200,000 worth of state money in educating that physician out the door by not licensing them."

Reciprocity — the long route to licensure

Licensure by examination is a piece of cake compared to reciprocity, the process by which a physician licensed in another state can obtain a Texas license.

Although anyone who holds another state's license or a Canadian license may apply for licensure by reciprocity, the board requires a voluminous amount of documentation, including professional references from the last 10 years of practice, records of hospital staff privileges and training programs, medical school transcripts, disciplinary action reports from the Federation of State Medical Boards, and more.

That documentation is needed to give the board some idea of the physician's professional competency or possible impairments, says Ivan Hurwitz, director of the board's licensure division. But critics of the process say it simply slows down licensure and discourages many highly competent physicians from moving to Texas.

Mr Hurwitz says the average processing time is about 10 or 12 weeks, but it can take as long as 2 years for a license to be issued or denied. Part of that time lag is due to a recent surge in reciprocity applications. The huge increase in physicians seeking to move to Texas has pushed the total applications to more than 1,000 for fiscal 1992, a jump from 761 just 2 years ago.

Attorneys who frequently represent out-of-state physicians in the reciprocity procedure complain that the documentation required is excessive and hard for the physician to compile because so many different people have to be contacted for references or records.

But Dr Goehrs does not apologize for the amount of documentation required.

"We have decided that it's probably a little better to . . . avoid the later problems of discipline by not licensing those physicians who have demonstrated poor practice in other states," Dr Goehrs says.

Dr Aguirre, who chairs the reciprocity committee, agrees that the board must be diligent in investigating doctors coming into Texas. "We have the obligation to make sure they can practice the same standard

Reciprocity applications stretching board licensing staff

If you're a physician, Texas seems to be the place to be.

A record number of physicians are moving to Texas and seeking licenses through reciprocal endorsement. In fact, Homer Goehrs, MD, executive director of the Texas State Board of Medical Examiners, says the number of physicians licensed by reciprocity will equal or surpass physicians licensed by examination next year.

The board licensed 828 physicians by reciprocity in fiscal 1991 compared to 1,076 by examination. This year, the board already has licensed 1,029 by reciprocity while issuing 1,102 licenses by examination. At the board's August meeting alone, the reciprocity committee approved 217 reciprocity applications.

"Those coming here by reciprocity have increased by about 40% in the last year and a half or so," Dr Goehrs says. "And that's been a load on us." (The board has not added any staff to handle reciprocity applications in more than a year.)

A recent board survey showed nearly one third of physicians coming to Texas do so for training. Family and financial reasons ranked second and third. Other reasons include climate, a desire to practice in underserved areas, military service, and previous residency in Texas.

Ivan Hurwitz, director of the board's licensing division, says a recent Texas Research League report suggested that some of the influx may be the result of statistics showing that Texas physicians on average make more money than physicians in other states.

of medicine that physicians are expected to practice by examination here," he says.

That attitude leads to another major complaint about the reciprocity process. The board requires all foreign medical graduates to complete 3 years of training in the United States to be eligible for a Texas license. Many doctors who have had long careers in other countries don't want to take additional training, but Dr Aguirre says it is the only way to ensure competency of physicians who come from countries where information on their training is hard to obtain or who graduated from "diploma mill" medical schools.

"It is unbelievable what kind of training people get outside the United States," Dr Aguirre says. "It could be excellent or it could be paper training."

Despite the stringency, most physicians who seek reciprocity get it. If all documentation is in order, a physician's application likely will be approved by the reciprocity committee on a routine vote along with hundreds of other applications. If there is a problem, the physician is afforded a hearing before that committee, but fewer than 10% of applicants go before the committee and a large percentage of them ultimately get their licenses.

Even when reciprocity applica-

FLEX pass rates high

Most Texas medical school graduates who sit for the licensing examination pass. The chart shows the pass rate for graduates of each of Texas' eight medical schools who took both the FLEX and the medical jurisprudence examination in June 1992. It also compares pass rates of out-of-state and foreign medical graduates to Texas graduates.

	Jurisprudence Exam			FLEX/Component I Exam			FLEX/Component II Exam		
	Total Examined	Percent Passed	Grade Average	Total Examined	Percent Passed	Grade Average	Total Examined	Percent Passed	Grade Average
The University of Texas Medical Branch at Galveston	149	89%	83	151	96%	80	153	98%	80
Baylor College of Medicine	116	97%	87	117	98%	83	117	99%	83
UT Southwestern Medical Center at Dallas	169	95%	86	176	98%	82	176	99%	82
UT Health Science Center at San Antonio	150	91%	84	153	94%	80	153	95%	80
UT Health Science Center at Houston	147	95%	85	150	97%	80	149	100%	80
Texas Tech University Health Sciences Center	86	87%	82	89	91%	79	87	94%	80
Texas A&M University College of Medicine	34	94%	84	34	97%	80	35	100%	81
Texas College of Osteopathic Medicine	40	100%	87	45	80%	77	40	88%	79
Total Texas Graduates	891	93%	84	915	95%	80	910	98%	81
Out-of-state graduates	98	83%	81	107	88%	80	100	95%	81
Total US graduates	989	92%	84	1,022	95%	80	1,010	97%	81
Canadian graduates	0	—	—	0	—	—	0	—	—
Foreign graduates	28	71%	79	30	97%	81	29	97%	81
TOTAL GRADUATES	1,017	91%	84	1,052	95%	80	1,039	97%	81

Applications for licensure by exam coming soon

Medical students who plan to graduate in June better get ready to start the licensing process. Ivan Hurwitz, director of the licensure division of the Texas State Board of Medical Examiners, says applications for licensure by examination likely will go out to all eight Texas allopathic and osteopathic medical schools this month or in December.

The completed application, along with the $800 examination fee, must be submitted by February 1 if a candidate for licensure is to sit for the FLEX exam in June. Between February and June, licensure division staff will process applications, run criminal history checks with the Department of Public Safety, and check on graduation status.

"We do pick up a few arrest records from the Department of Public Safety and a few alcohol and drug abuse problems that show up in medical school," Mr Hurwitz says. The vast majority of applicants, however, have no problems and are allowed to sit for the exam.

Those with criminal records or histories of drug or alcohol abuse may be allowed to sit for the exam, but usually must go before the board or its examinations committee before getting their license.

Medical graduates who pass both the FLEX and the Texas medical jurisprudence exam must complete 1 year of training before actually getting their medical licenses. In fact, most graduates begin residencies in July before the results of the June test are known.

Mr Hurwitz says the whole process takes nearly 2 years because the board needs almost 6 months to issue all the licenses after evidence of the first year's training is provided. However, a physician can obtain a temporary license while waiting for the permanent license to be issued.

Hotline provides public information, starting point for complaint process

Anyone who wants to find out whether a physician has ever been disciplined by the Texas State Board of Medical Examiners simply can reach for the telephone.

The board averages nearly 1,000 calls per month to its toll-free hotline number. The number, (800) 248-4062, is published under the government listings in the telephone directories of 10 Texas cities.

Callers can find out which medical school a physician attended, what year he or she graduated, and any disciplinary action taken against the physician by the board.

The hotline also can serve as a starting point for filing complaints against physicians. Although callers cannot actually lodge complaints over the telephone — only written complaints are accepted — callers can request a copy of the board's complaint form.

Homer Goehrs, MD, the board's executive director, says calls to the hotline have more than doubled in the past 2 years. Through the first 10 months of fiscal 1992, the board received 9,540 calls to the hotline. That compares to 6,963 for fiscal 1991 and 4,793 in fiscal 1990. Calls totaled fewer than 1,000 during fiscal 1988.

tions are rejected, physicians can and do take the matter to state district court. The courts have reversed several board decisions, requiring the board to license physicians it felt were not qualified.

Discipline not an exact science

Despite the board's efforts to choose carefully those physicians it licenses, some physicians do get into trouble. While the board's job is to protect the public from those who cannot competently practice medicine, as much dispute exists about what constitutes "protecting the public" as about everything else the board does.

The board receives about 1,800 complaints against physicians each year. Many are trivial, some extremely serious. Regardless, all are screened by the board's investigations division. If it determines that a complaint, if true, would constitute a violation of the Medical Practice Act, an investigation is launched, says Paul Gavia, JD, director of the investigations division. However, 75% of all complaints are dropped in the investigative stage.

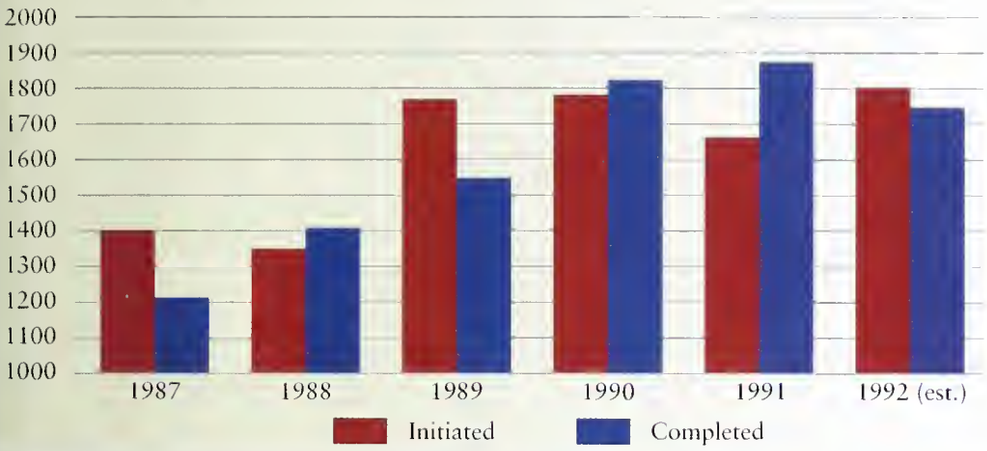
Only about half of the remaining cases result in disciplinary action, and Ms Jenkins and Dr Stasney complain that too many of the really bad doctors get off with slaps on the wrist, while some with only minor violations get slapped down hard.

"I'm frustrated," Dr Stasney says. "I've been on the board for 5 years and the same bad doctors from Harris County that the Harris County Medical Society has been upset with for 15 years are still practicing medicine. I'm frustrated that we're not able to take care of the really bad apples and we seem to pick on the poor little guy who got in trouble with alcohol or cocaine and is doing everything in his or her power to get back to the practice of medicine without the influence of alcohol or drugs."

Dr Stasney admits that the alco-

INVESTIGATIONS INITIATED AND COMPLETED

Chart shows numbers of investigations initiated and completed by the investigation division of the Texas State Board of Medical Examiners since fiscal year 1987. Data for 1992 are estimated.



hol and drug abuse cases are much easier for the board to prove than those involving medical incompetence or flagrant overcharging and overtreating. Still, he complains that some board members simply will not take tough action against some physicians because of their personal or professional philosophies. That creates a wide variation in the severity of discipline in cases with similar fact situations because the entire board does not hear every case.

Instead, the majority of cases are heard in "informal settlement conferences," in which only two board members, or a board member and a physician from one of the board's district review committees, meet with the physician to resolve allegations. At these conferences, board members have wide latitude to dismiss cases or recommend disciplinary action. The range of punishments is the same that the full board can mete out — from a public reprimand to license revocation.

Dr Stasney says too many cases get dismissed at the settlement conference stage.

"I dismiss about 25% of the sanctions I hear with one other district review person," he says. "There are other people on the board who dismiss 75%."

That bothers Dr Stasney because the cases that make it to informal settlement conferences already have been determined by board investigators and attorneys to represent probable violations of the Medical Practice Act.

"These are distilled cases," he says. "There's got to be some kind of middle ground there for the board to work through and have consistency and standards so the same sort of violation gets the same sort of penalty.

"When this guy dismisses 75% of the distilled cases it bothers me because I believe those people have violated the Medical Practice Act."

Ms Jenkins wants tougher action to be required of board members. "I think the legislature needs to tighten up our laws so that we're required to revoke on more cases than we do now," she says.

Despite the high dismissal rate at the conference stage, attorneys who represent physicians at such conferences say their clients don't always walk away happy.

In fact, they complain that the conferences are neither "informal" nor "settlement" conferences. Instead, one attorney described the process as "mini-hearings" that offer little due process to the physician, who often is asked to respond with inadequate knowledge of the complaint. The board panel then goes into executive session with the staff attorney to settle on the punishment, without discussion or negotiation with the physician.

Despite the conflict over the conferences, this is how three fourths of cases that result in discipline are settled. That means very few cases go to full administrative hearings and, eventually, to the full board for action. In fiscal 1991, 265 cases went beyond the investigative stage, but only 15 went on to full hearings. Discipline resulting from these cases included revocation of 15 physicians' licenses, suspension of 9 licenses, 96 probations or license restrictions, and 8 reprimands.

INVESTIGATOR CASELOAD STAGGERING

THE DISCIPLINARY process can take months or years to play out. Each of the board's 18 investigators — mostly registered nurses — handle as many as 65 to 75 cases at a time. That compares to a caseload of about 35 per investigator at the California medical board.

Because of the caseload, investigations must be prioritized, many getting little attention for weeks at a time. An emergency request for funds to hire more investigators has been on Gov Ann Richards' desk since March without action.

Even when an investigation is completed and the board comes down hard on a physician — revoking a license or suspending it pending a hearing because of imminent danger to the public — the case can drag out longer because of appeals to the district courts.

"We are not the final word for these doctors," says board member Penny Angelo of Midland. "If the doctor chooses to go to court and we get reversed, we don't have a leg to stand on."

That happens frequently. A case in point was that of Hugo Ramirez, MD, the Pasadena physician of one patient who died and another who became critically ill following liposuction surgery in 1987. When the board took

Sunset to revive debate over consolidation of agencies and other turf battles

The debate initiated in 1991 over consolidating all state licensing agencies almost certainly will be renewed — but on a smaller scale — when the Sunset Commission issues its recommendations for reauthorizing the Texas State Board of Medical Examiners and other licensing agencies next year.

Bill Wells, executive director of the Sunset Commission, says preliminary staff recommendations will include combining some administrative functions of those boards. However, an all-encompassing licensing and regulatory agency, as proposed in 1991, will not be included.

Mr Wells says the Sunset Commission staff, whose recommendations were due in mid-October, is considering moving the regulatory agencies — including 20 health-related agencies up for review in 1993 — into a centralized building complex. That would allow for shared administrative functions, such as printing, copying, and telephone services.

"We're trying to combine some of the hardware type of things," he says. But there will be no merging of employees, he adds.

Another recommendation almost certain to be included in the staff report is increasing the number of public members on the Board of Medical Examiners from three to five. Mr Wells says the commission has a "rule of thumb" that one third of regulatory board slots should go to public members. The Texas Health Policy Task Force also has included that recommendation among several board reforms proposed in its preliminary report.

The commission probably will hold public hearings on the preliminary recommendations in November, and the final report is to be presented to the legislature in January.

TMA President William G. Gamel, MD, of Austin, recently appointed a special task force to monitor the sunset process. That panel is chaired by former TMA President Wm. Gordon McGee, MD, El Paso, and includes several attorneys with experience practicing before the medical board.

Kim Ross, TMA director of public affairs, says the task force not only is analyzing recommendations from the Sunset Commission staff and other sources but it is developing proposals of its own. "TMA has been conducting a peer review parallel to what the board is going through," Mr Ross says.

Another major concern for TMA is the sunset review of the state's 19 other health professional licensing agencies, including those that regulate dentists, nurses, chiropractors, pharmacists, and others. Many allied health groups are expected to try to use the sunset review process to carve out larger niches for themselves in the health-care industry.

"The nurses, the chiropractors, the psychologists all have an agenda," Mr Ross says. "All will go through sunset. It will be like playing 20 different games of chicken at once."

He says the other health professional licensing agencies are more vulnerable in the political process than physicians. "Some of those boards haven't lifted a license in more than 10 years. They have an incestuous relationship with their licensees and they are radically understaffed," he says. "We're going to focus on what's right and what's wrong with the Board of Medical Examiners and what we come up with for them we're going to recommend for all the licensing boards."

immediate action to suspend his license, a judge stayed the action pending a full hearing. Dr Ramirez continued in practice for several additional months before his license was revoked.

Physicians whose licenses are placed on probationary status are monitored by compliance officers. Monitoring programs include random urinalysis for those who have had alcohol or drug problems.

Again, unfortunately, this function of the board is hampered by too few staff. Only two compliance officers monitor the current load of 340 probationers, although many physicians with chemical dependency problems are monitored through county medical society committees. Executive director Dr Goehrs says a third compliance officer is being hired, but Ms Jenkins says the caseload needs to be no more than 60 probationers per officer.

"I saw one (physician) in informal settlement not long ago who went close to a year with no urine screens and he was drinking and drugging the whole time," she says.

Still, Dr Goehrs says many other state boards place physicians on probation with no compliance officers to keep tabs on them. "We're one of the few states that have compliance officers," he says.

Funding, reforms top issues for 1993

The myriad controversies facing the medical board will, no doubt, be hashed out during the sunset review process and budget debate. Mr Ross says many of the administrative headaches, time delays, and other problems simply are a result of budget constraints that prevent the board from hiring an adequate number of staff to handle its increasing workload or to retain well-trained staff members who can get higher salaries elsewhere.

"Since the last session of the legislature, TMA has supported

Dr Goehrs' requests for emergency appropriations to increase the pay scales and to add to the number of compliance officers," he says. "There are demonstrable personnel needs, in fact, that ought to be expedited."

Mr Ross adds that many of the board's problems are because Texas has a tradition of giving only minimum levels of support to its regulatory agencies.

"They are chronically underfunded and understaffed," he says.

"When you compare the way the Board of Medical Examiners functions to other health licensing agencies or other licensing agencies period in Texas, they're a paragon —they're the best. To an optimist, that sounds great. To a cynic, it's disturbing."

Suggestions for reforming the medical board are plentiful from nearly every corner, including the Texas Health Policy Task Force, which is to issue its final report this month. Ms Jenkins and Dr Stasney have suggested legislative and regulatory changes to bring more consistency to board actions. TMA supports that effort.

An ad hoc panel of experts recently created by TMA President Dr Gamel has been charged with looking at, among other issues, the question of whether disciplinary guidelines can be developed.

"The answer is we need to try," says Mr Ross, but he cautions that similar efforts by the criminal justice system to create sentencing guidelines have been disappointing. "We need to see if parameters could be created that still give board members some discretion. Surely we can establish patterns of disciplinary options in which one board member can't be too harsh and another too lenient."

Another TMA priority will include increasing the state's authority over physicians — and other health professionals — who persistently or flagrantly overcharge and overtreat. In response to a questionnaire distributed by the Sunset Commission, TMA suggested granting the state attorney general oversight of these and other areas of fraudulent and unauthorized practice, but it also recommends that the same rules apply to all health professional licensees.

Dr Gamel explains that what is at stake is whether physicians maintain their status as professionals or become regulated as businesses.

"There is a higher standard to which we must adhere if physicians want to remain a profession," he says.

Among other suggestions heard for reforming the medical board are increasing the number of its public members and depoliticizing the board member appointment process.

Some physician board members contend increasing the number of public members and decreasing the physician members will greatly increase the workload on physicians in hearing settlement conferences, since any complaint involving medical judgment must be heard by at least one physician. Mr Ross, however, says TMA will not oppose more public members on the board if that proposal is applied across the board to all health professional licensing agencies, including those governing chiropractors, nurses, pharmacists, and others.

TMA also supports depoliticizing the appointment process. "There's no way, as long as you have gubernatorial appointments, ever to completely sterilize the politics," Mr Ross says, but TMA would like to see criteria established for selecting board members, such as experience with peer review or substance abuse counseling.

Dr Goehrs' own goals for sunset include securing adequate funding to hire staff to process licensure applications promptly and efficiently, upgrading the investigative staff, and preventing the board's legal staff from being transferred into the attorney general's office, a proposal he says will jeopardize the progress the board has made in attracting and retaining experienced attorneys.

No time to blink

GIVEN ALL THE controversy swirling about the Texas State Board of Medical Examiners and the Medical Practice Act, what is critical for Texas physicians, says Dr Gamel, is to maintain a keen sense of priority.

"We must know what is worth fighting over and what we will negotiate. We cannot ride a single issue, but rather must hold true to a series of related objectives centered on preserving and enhancing the autonomous practice of medicine in Texas. It is hard for physicians to accept certain restrictions in order to maintain that autonomy, but there will be nothing free in this next session. Whatever we put in, we're going to have to take out something else."

But there will be no blinking on the part of TMA, he says. "We will not be bluffed. If someone tries to hold the medical board and the Medical Practice Act hostage until we agree to something that we don't think is in the public's best interest, then we're prepared to say 'Fine, you kill the bill and throw us back into the dark ages.'

"Too many Texans are getting unconventional and ineffective AIDS and cancer treatments from nonphysicians who ought to be regulated. To those who say caveat emptor, we must respond, 'When it comes to the general public distinguishing between podiatry, chiropractic, and physical therapy, or between psychiatry and psychology, or between optometry and ophthalmology, they simply cannot always tell the difference." ★

Medical Economics

TMA committee makes recommendations on electronic claims filing

BETWEEN FILING MYRIAD insurance claims and complying with government regulations, physicians' staff members are spending an increasing amount of time filling out a seemingly endless array of forms. But a growing number of physicians are discovering that computerized electronic claims filing can eliminate a large part of the paper blizzard.

While many physicians are finding that computerized electronic media claims (EMC) can both speed up the process and improve their practice's cash flow, the system for filing claims is still evolving and it is not without problems.

The Texas Medical Association's Council on Socioeconomics has appointed an Ad Hoc Committee on Electronic Media Claims to study the issues and make recommendations. The committee, chaired by Robert Vanzant, MD, a Houston family practitioner, met September 18 in Austin to study the use of EMC to provide a better understanding of electronic billing from the users' point of view, to identify problem areas of EMC and make suggestions for their resolution, and to make recommendations to Blue Cross and Blue Shield and other insurers on how to meet users' EMC needs.

"This was more of an organizational meeting," he said. "We're looking at what type of systems are out there, what pitfalls to avoid, and what services TMA should be providing its members in this area. It was mainly a brainstorming session."

He said the committee studied such possibilities as reviewing and recommending hardware and software vendors, offering training sessions on EMC to physicians and their office staff members, and even operating a claims clearinghouse for TMA physicians, if the need is there.

According to Crawford Guthrie, director of provider automation for Blue Cross and Blue Shield of Texas, the volume of EMC has increased steadily during the past 8 years. (See chart.) He added that Blue Cross and Blue Shield of Texas, which not only processes claims from its own policies but also Medicare and Medicaid claims, is the largest single processor of EMC in the state.

The requirements to file EMC are fairly simple, according to Mr Guthrie. An office needs only a relatively small computer system with appropriate software and telecommunications capability. The cost of systems ranges from a few thousand dollars for a basic system to much more for a high-end system.

"There are three major advantages to electronic claims: faster turnaround time, greater control, and increased accuracy," he said. "On the turnaround, at the very least, you get rid of all the front-end handling on any kind of claim. There's a lot of 'fumble time' both in the doctor's office and on our end that you get rid of. A doctor also gets the check back a lot more quickly than if a paper claim is filed."

> "THERE ARE THREE MAJOR ADVANTAGES TO ELECTRONIC CLAIMS: FASTER TURNAROUND TIME, GREATER CONTROL, AND INCREASED ACCURACY."

He said that checking a filer's system before they begin sending claims ensures a higher degree of accuracy for the physician.

"We clean up a lot of problem billing practices through the testing process," he said. "Once we complete that, they come out with a much cleaner product than you had before, so you have greater accuracy on the front end."

Electronic filing also gives the physician more say over the codes on the claim.

"The doctor controls what goes on the claim," Mr Guthrie said. "If he wants to control how the claims are coded, then he does, and the claim goes straight into the system. Nobody pulls it out and changes it."

Electronic media claims filing 1984–1992, Blue Cross and Blue Shield of Texas*

Calendar Year	Electronic Claims	Total Claims	EMC % of Total
1984	3,451,724	18,503,907	18.7
1985	4,296,496	18,655,394	23.0
1986	5,899,474	19,786,195	29.8
1987	8,080,945	22,857,231	35.4
1988	9,337,878	25,384,592	36.8
1989	9,752,931	25,232,246	38.7
1990	11,931,868	32,318,635	37.0
1991	15,891,738	36,057,274	44.1
1992†	12,380,295	25,576,821	48.4

*Statistics for all claims handled, including BC/BC claims, Medicare, and Medicaid.
† Figures complete through August.

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

He adds that when a claim is filed electronically, the physician's office receives an immediate acknowledgment that it was received or has been rejected due to an error.

Both Mr Guthrie and Dr Vanzant feel that the march towards universal use of EMC is inevitable.

"It's just the way technology is going," Mr Guthrie said. "A group known as the Workgroup for Electronic Data Interchange is developing a national standard for EMC that will eventually allow any doctor to file to any carriers using the same standard electronic form, as well as provide for electronic remittance (automatic payment from the carrier directly to the physician's bank account)."

Dr Vanzant agrees that electronic claims are coming, whether anyone likes it or not.

"Medicare has the legal authority to start charging for paper claims, but they haven't done it yet," he said. "But they could certainly make it uncomfortable to send paper claims."

He adds that many of the national health-care reform proposals being studied in Washington would mandate EMC as a cost-cutting measure, forcing physicians to convert their billing.

He added that almost all major carriers have geared up for EMC in the past few years and that TMA will be looking at numerous options in terms of assisting its members to move into the electronic age of claims.

The committee agreed to meet again to study additional aspects of electonic claims filing. No meeting date was determined. The committee eventually will forward a set of recommendations to the Council on Socioeconomics.

Liability premium discounts still available

TEXAS PHYSICIANS HAVE until September 1, 1995, to take advantage of a law passed in 1989 that provides discounts on premiums for professional liability insurance.

House Bill 18, which went into effect January 1, 1990, allows physicians who complete continuing education in risk management and deliver charity care to a portion of their patients to receive a reduction in their liability premiums.

To be eligible for the program, a physician must meet the following criteria:

- have a valid professional liability insurance policy for medical malpractice with limits of $100,000 per occurrence and $300,000 aggregate for the policy period;
- complete 15 hours of continuing education in risk reduction and patient safety during the term of your policy; and
- deliver charity care in at least 10% of your patient encounters.

Under the program, for physicians who qualify, the state will be liable for payment for actual damages of an award against a physician.

Charity care under the program is defined as services to patients under:

- treatment for emergency patients encountered to the extent the physician is not compensated;
- Medicaid;
- Texas Department of Health (TDH) Maternal and Infant Health Improvement Act;
- Texas Department of Human Services County Indigent Health Care Program;
- TDH Primary Health Care Services Program;
- TDH Chronically Ill and Disabled Children's Services Program; or
- a contract with a federally funded migrant and/or community health center.

To qualify for the premium discount, a physician must notify his or her liability carrier at the time of application or renewal, stating the intention to meet the charity care work load and to take 15 hours of CME.

Insurers have the right to audit the records of physicians who receive discounts at the end of the policy to determine if appropriate charity care was provided and CME was completed. If an audit determines otherwise, the physician will be charged the full premium, plus a 20% penalty. To avoid the penalty, physicians must notify insurers 30 days before the end of the policy period if they have not fulfilled requirements.

TMA's Risk Management Department conducts a series of risk management workshops on a regular basis to assist physicians in meeting the CME requirements of HB 18.

The seminar "From Deposition to Courtroom" consists of a 3-hour seminar and a 12-hour home study program with videotapes and a workbook. The program "Defend Yourself" is a 15-hour home study program. One other seminar, "Carcinoma of the Breast: Clinical and Risk Management Issues," offered by TMA, meets the HB 18 requirements.

Three sessions of "From Deposition to Courtroom" are scheduled before the end of 1992: November 12 in Amarillo, November 19 in San

Antonio, and December 3 in Abilene. Another series is scheduled for early 1993. Remaining "Carcinoma of the Breast" seminars are scheduled for November 11 in McAllen and December 2 in Austin.

"From Deposition to Courtroom" and "Carcinoma of the Breast" cost $185 for TMA members and $285 for nonmembers. "Defend Yourself" is $150 for TMA members and $250 for nonmembers. To register or order the program, call TMA Risk Management at (800) 880-1300 or (512) 370-1410. ★

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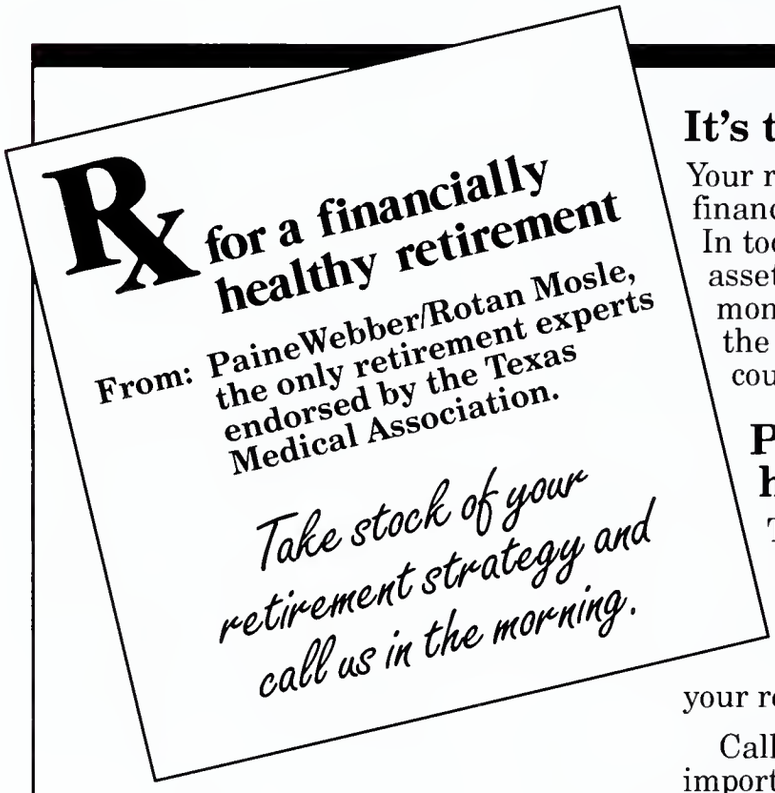

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Law

What role do expert witnesses play in malpractice lawsuits?

Bernard D. Hirsh, JD
Wildman, Harrold, Allen & Dixon
Chicago, Ill

Donald P. Wilcox, JD
TMA General Counsel

THE INVOLVEMENT OF AN expert witness is a powerful incentive for misrepresentations and temptation to inflate damages and enhance testimony in a medical malpractice case. The incentive is just as great for a consultant or witness broker, whose compensation is linked to the size of the plaintiff's recovery, to manufacture testimony through selective procurement of expert witnesses.

Five of the medical tort reform bills now before the US Congress place limits on the fees plaintiff lawyers may charge for handling malpractice claims. The more serious problems of contingent fees for medical testimony based upon the amount of damages recovered are not addressed in the bills. Contingent fees paid to consulting firms for selecting and preparing expert medical witnesses to testify in malpractice cases may be as much as 20% of the gross recovery. The contingent fees paid to the plaintiff's lawyer and consultants along with fees paid to expert witnesses and other costs of litigation often may amount to more than half of the recovery.

Only a few state courts have ruled upon the validity of a contract providing for payment of a contingent fee based upon the amount recovered in a medical malpractice action for procuring medical testimony. Such agreements in Maryland have been held not to violate public policy, but in New Jersey and Michigan contingent fee for medical testimony was held inimical to the administration of justice and therefore invalid as violative of public policy. In Texas, legal ethics prohibit contingency fees for witnesses or entities that arrange for witnesses.

The following cases are examples of the role expert witnesses play when providing testimony in medical professional liability lawsuits.

IN TEXAS, LEGAL ETHICS PROHIBIT CONTINGENCY FEES FOR WITNESSES OR ENTITIES THAT ARRANGE FOR WITNESSES.

Case study 1

Schachow v Medical-Legal Consulting Services, Inc, 416 A2d 1303 (1980).

This case illustrates the financial incentives to locate a qualified doctor to testify as an expert witness that the defendant's medical treatment of the plaintiff was malpractice.

Gerald Schachow was trial counsel for the successful plaintiff in a complex medical malpractice action tried before a jury in Gainesville, Fla. Medical-Legal Consulting Services, Inc (MLCS), a Maryland corporation engaged in the business of providing consulting services to attorneys in the preparation of cases involving medicolegal issues, brought suit against Mr Schachow in Maryland to enforce payment of a 10% contingent fee for services rendered under a consulting agreement with Mr Schachow and his client. The total recovery in the malpractice action was $1,435,000.

The suit had its genesis when John Dixon suffered an injury while waterskiing. Twelve days after his fall, Mr Dixon went to his family physician with symptoms of headaches, personality changes, and amnesia. His physician prescribed Midrin and scheduled a routine neurological examination with a neurologist. Two days before the exam, Mr Dixon went to the emergency room still complaining of the same symptoms. He was hospitalized by the neurologist with whom his routine examination had been scheduled.

The skull x-ray and brain scan were performed on Mr Dixon the morning following his admission to the hospital. The radiologist interpreted the scan between 7:30 am and 10:55 am that morning. It was his opinion that Mr Dixon had a subdural hematoma. The report and opinion were transmitted routinely to the neurologist. Meanwhile, Mr Dixon's condition was rapidly deteriorating. At 12:45 pm, the pressure from the expanding hematoma caused a portion of the brain to herniate by protruding into a sinus cavity. An hour later a neurosurgeon bored emergency and temporary burr holes to relieve the pressure. Subsequently, complete surgical procedures were employed to remove the hematoma. Due to the herniation of his brain, caused by a delay in proper medical treatment, Mr Dixon was rendered cortically blind, mentally incompetent, and a quadriplegic.

Mrs Dixon employed Mr Schachow, the defendant in this case, to file a malpractice suit against the health-care providers who treated her husband. Although Mr Schachow possessed substantial trial experience, he had never previously

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

handled a medical malpractice suit. He embarked upon a search for help in assembling a case against the physicians and the hospital. The plaintiff, MLCS, was recommended to him as a firm that provided consulting services to assist attorneys in preparing medically oriented litigation and in locating physicians willing to testify. Thereafter, a contract for assistance in the preparation of the case was entered into between MLCS, Mr Schachow, and Mrs Dixon. Under the agreement, MLCS would receive a percentage of the recovery on a graduated basis. MLCS would be paid 10% if the recovery exceeded $1 million. MLCS' fee was in addition to the fixed fees that would be paid to the expert medical witnesses who would testify.

MLCS contacted three eminent neurologists and a radiologist who after reviewing Mr Dixon's medical records and brain scan declined to testify because they found no malpractice in the treatment Mr Dixon received. Two general practitioners were located by MLCS who testified at the trial that the physician who Mr Dixon first visited violated the standard of care for general practitioners in Florida. The radiologist and neurologist who treated Mr Dixon obtained directed verdicts because the plaintiff had no experts to testify against them. The jury returned a verdict against Mr Dixon's family physician, the remaining defendant, in the amount of $1.5 million, which was settled in lieu of an appeal for $1,435,000 (including $35,000 in settlement from the hospital). MLCS's 10% share of the recovery, pursuant to its contract with Mrs Dixon and Mr Schachow was $142,051.25.

MLCS sued Mr Schachow. He had agreed that the 10% fee for MLCS would be paid from his attorney's fee, which was 47.5% of the recovery. After some adjustments by the trial court, judgment for MLCS was entered for $130,351.25. On appeal, Mr Schachow argued that the contingent fee agreement with MLCS violated public policy. In affirming the judgment of the trial court, the Maryland Court of Special Appeals responded: "All the experts were to be paid a flat fee by the client. MLCS' role was limited to locating potential experts and then educating them about the case for Mr Schachow. That arrangement does not violate the public policy of Maryland."

EVIDENCE SHOULD NOT BE ALLOWED IF OBTAINED THROUGH CONTINGENT FEE ARRANGEMENTS.

Case study 2

Medical-Legal Consulting Services, Inc v Covarrubias, 285 CalRptr 559 (1991).

A medicolegal consulting firm was fired after its client settled a malpractice action. The consulting firm had contracted with the plaintiff child's parents and their attorney to provide medicolegal consulting services in the preparation and trial of a pending lawsuit against a hospital and several physicians.

Under the terms of the contract, Medical-Legal Consulting Service, Inc (MLCS) agreed to prepare a medicolegal case analysis, conduct an initial strategy and teaching conference, assist in the selection and preparation of expert witnesses, and assist in settlement conferences and trial preparation. For its services, MLCS would receive 10% of any settlement or 15% of the verdict if the case went to trial. The contract also provided that laws of the state of Maryland would govern the interpretation and enforcement of the contract.

Ten months after the contract was signed, the malpractice suit that had been pending in a Los Angeles trial court was settled. Under terms of the settlement, the minor plaintiff would receive a lifetime annuity, an immediate payment of $200,965, two lump sum payments of $500,000 (one 25 years and one 50 years after the settlement), and $8,750 in costs. The plaintiff's attorney would be paid $91,675 immediately and $601,586 after the date of the settlement. The parents received $100,000.

Shortly after the settlement, the child's attorney and his parents fired MLCS without paying the fee provided in the contract. On December 10, 1985, MLCS filed suit in Maryland against the parents individually and as guardians for their minor son. The trial court subsequently awarded MLCS $157,000 plus interest of $28,305 and costs. The parents individually and as guardians appealed the judgment. While the appeal was pending, the minor, through his guardians and MLCS, entered into a settlement of their dispute, which was subject to the approval of the Los Angeles Superior Court judge because the proceeds of the malpractice suit were in a blocked account. A petition to withdraw $100,000 from the $397,075 remaining in the blocked account, however, was denied.

On May 2, 1988, MLCS then filed its application in the Los Angeles Superior Court for entry of the Maryland judgment against the par-

ents individually and as their minor son's guardians. The trial court decided that the Maryland judgment for MLCS was void and not enforceable in California. On appeal, the parents, on their own behalf and as guardians for their minor son, argued that the contract violated the limitations on payments to attorneys under California law. In reversing the trial court, the California Court of Appeals held that the Maryland judgment was enforceable as a California judgment. The appeals court said that the California statute limiting attorney's fees was not an "issue of such importance" to permit one state to refuse to enforce a judgment of another state's court.

If this case had been decided originally under California law, the consulting firm's contingent fee agreement probably would have been declared invalid. The Court of Appeals cited with approval *Von Kessler v Baker*, 131 Cal App 654 (1933), in which the court held that a contract for payment of 25% of the recovery or 20% of settlement to an expert witness was void as tending to impair the administration of justice and, hence, contrary to public policy. Previously, the California Supreme Court in *Hare v McGue*, 174 P 663, stated as a rule of law that: "A contract is void whereby one agrees to obtain or procure testimony of certain facts which will successfully support or defeat a lawsuit, or which provides that payment to the person procuring such testimony is to be contingent upon the result of the action for which he is engaged to procure it."

Case study 3

Dupree v Malpractice Research, Inc, 445 N E 2d 498 (1989).

The plaintiffs contracted with the defendant to provide expert medical testimony, as well as advice on trial techniques, for plaintiffs' malpractice action in exchange for, among other things, 20% of plaintiffs' eventual recovery.

Leslie Dupree and her parents filed a malpractice action to recover damages for injuries she had suffered at birth. Apparently unable to locate necessary and qualified experts locally to evaluate and provide expert testimony to support his clients' malpractice action, the plaintiffs' attorney responded to an advertisement in the *Michigan Bar Journal* placed by H. Barry Jacobs, MD, doing business as the Medical Quality Foundation, Herndon, Va.

After reviewing with Dr Jacobs the various contractual agreements available with Malpractice Research, Inc, the plaintiffs' attorney permitted his clients to sign a contract that was accepted by Dr Jacobs personally and on behalf of Malpractice Research. The contract contained a number of conditions under which Dr Jacobs would make himself and expert witnesses available to the plaintiffs. The contract also set forth a schedule of expert witness fees, travel costs, and other expenses payable by the plaintiffs in advance of any services rendered and which were separate and in addition to the 20% contingency fee to be paid to Malpractice Research.

As the matter proceeded, Malpractice Research provided the plaintiffs' attorney with access to several medical experts on its consulting staff and provided considerable advice on trial techniques with suggested supporting expert testimony. The malpractice action was eventually settled for $170,000. According to the contract, Malpractice Research was owed 20% of the settlement, or $34,000. During the course of the malpractice action, plaintiffs paid to Malpractice Research at least $2,775 in fees and costs.

Plaintiffs then filed this suit for declaratory relief seeking rescission of its contract with Malpractice Research. Both sides moved for summary disposition based on the record without a trial. The trial court found the contingency fee agreement invalid and unenforceable as violative of public policy. The trial court then refused to consider the defendant's quantum merit claims to be paid for the value of the services it had rendered. In affirming the judgment of the trial court, the Michigan Court of Appeals said, "we find contingent fee contracts of the type at issue so repugnant to established Michigan public policy . . . that to permit recovery on a quantum merit basis would defeat or subvert those policies and threaten the integrity of the judicial system. . . . The fact that Dr Jacobs operates his business essentially as a middleman for the medical experts on his consulting staff is of no consequence."

Case study 4

Polo v Gotchel, 542 A2d 947 (1987).

Plaintiff Christi Polo, by her mother and legal guardian, instituted a malpractice action for birth injuries against the obstetrician who delivered her. Plaintiff's guardian, upon recommendation of legal counsel, contracted with JD-MD, Inc, to evaluate the merits of the case and to locate expert medical witnesses to testify at trial.

The contract provided that the plaintiff would pay the fees for the services rendered by expert witnesses, and JD-MD, Inc, would be paid a contingency fee of 6% of the amount recovered by either settle-

ment or verdict at trial. After the case was disposed of by compromise and settlement, the court considered the validity of the contingent fee agreement with JD-MD, Inc. In holding the contingent fee arrangement void as against public policy, the court cited an opinion of the Judicial Council of the American Medical Association. Opinion 8.04 states that a physician's fee should be based upon the value of his or her services "and not on the uncertain outcome of a contingency." The 1992 edition of *Current Opinions* of the AMA Council on Ethical and Judicial Affairs prohibits fees for testimony, contingent on the outcome of litigation in Code of Medical Ethics, *Current Opinions*, Section 9.07, AMA, 1992.

Under the Texas Disciplinary Rules of Professional Conduct (Rule 3.04[b]), a lawyer shall not pay or acquiesce in the offer or payment of compensation to a witness or other entity contingent upon the content of the testimony of the witness or outcome of the case.

Although violation of the Rules of Professional Conduct can result in disciplinary action, evidence obtained in a manner that violates the rules is still admissible as found in *Barnlam v Turner Construction Co of Texas* (App 5 Dist 1990) 803 SW 2d 731.

Federal and state medical tort reform legislation is needed to invalidate contingent fee arrangement with medical witnesses and consulting firms that are in the business of selecting medical witnesses who will testify favorably for malpractice claimants. Evidence should not be allowed if obtained through contingent fee arrangements.

Lawyers should be free to obtain information by discovery or in open court at trial concerning fees paid to medical witnesses and the financial interest of any consulting firm or middleman in the selection of the medical witness. To discourage lawyers prone to employ an unnecessary number of expert medical witnesses, such as in cases involving birth-related injuries, lawyers' contingent fees should be based upon the net recovery, after the deduction of payments to expert witnesses and other costs.

Physicians discover maze of regulations under ADA

Hugh M. Barton, JD
TMA Assistant General Counsel

Under the Americans with Disabilities Act (ADA), physicians have certain legal responsibilities towards disabled patients. The federal law went into effect January 26, 1992.

Q: What types of problems have been encountered in this area?

A: Physicians have been informed by legal foundations representing the hearing disabled that "qualified interpreters" must be available in order to avoid discrimination against patients or the parent of a patient who is deaf or hearing impaired. In some cases, a new patient will appear at the physician's office accompanied by an interpreter who then bills the physician for signing for the patient (or the parent of a minor). A letter to this effect was sent to all El Paso physicians and was interpreted by the medical community as rather aggressive.

Q: What is actually required?

A: Much misunderstanding exists about just what the ADA does or does not require. Title III of the ADA contains a "specific prohibition" against discrimination that includes the following:

> A failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied service, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the goods, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden (1).

The regulations published pursuant to the ADA discuss this in considerable detail. The section titled "Effective Communication" is worth reviewing:

> A public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities (2).

The regulation also states:

> If provision of a particular auxiliary aid . . . by a public accommodation would result in . . . an undue burden, ie, significant difficulty or expense, the public accommodation shall provide an alternative auxiliary, aid, or service if one exists that would not result in an alteration of such burden but would nevertheless ensure that . . . individuals with disabilities receive the . . . services . . . offered by the public accommodation (3).

The official comments to the final regulations are rather blunt:

> . . . In those situations requiring an interpreter, the public accommodation must secure the services of a qualified interpreter, unless an undue burden would result (4).

Q: Must I hire an interpreter at my expense just because a deaf patient wants one?

A: In the official comments, the US Justice Department states that the ADA's legislative history shows that Congress did not intend to impose upon a physician (or any other "public accommodation") the requirement that they give "primary consideration" to the disabled patient's requests. Rather, the legislative history demonstrates congressional intent to strongly encourage consulting with disabled persons. In other words, the Justice Department strongly encourages physicians to consult their disabled patients about such matters rather than mandating that they are automatically bound by an "expressed choice" for an interpreter (5).

Q: Do the official comments address physicians' offices specifically?

A: Yes. In analyzing the proposed rules, the Justice Department used as an example the situation in which a note pad and written materials would be insufficient to permit effective communication in a doctor's office when the matter to be decided was whether major surgery was necessary. Many who commented objected on grounds that it gave the impression that only decisions about major surgery would merit the provision of a sign language interpreter. They also claimed the statement would convey the impression that written communications would meet requirements in all but the most extreme situations. In response, the Justice Department stated that it did not intend to limit the provision of interpreter services to the most extreme situations by using the example of major surgery. The Justice Department added:

> Other situations may also require the use of interpreters to ensure effective communication depending on the facts of the particular case. It is not difficult to imagine a wide range of communications involving areas such as health, legal matters, and finances that would be sufficiently lengthy or complex to require an interpreter for effective communication. In some situations, an effective alternative to use of a note pad or an interpreter may be the use of a computer terminal on which the representatives of the public accommodation and the customer or client can exchange typewritten messages (6).

An interpreter should not be needed if the patient can read the questions and complete the form.

Q: What are advocacy groups saying about this?

A: Statements made by groups for the hearing impaired seem to go far beyond the official comments. One example comes from the "ADA Communication Accommodations Project," a joint program of the American Foundation for the Blind and the National Center for Law and Deafness and funded by the Department of Justice. The following statement is from their "Memorandum on the Obligations of Doctors and Other Health Care Providers Under the Americans with Disabilities Act":

> Typical examples of situations in which interpreters should be present are obtaining a medical history, obtaining informed consent and permission for treatment, obtaining diagnoses, treatment and prognosis of an illness, conducting psychotherapy, communicating prior to or after major medical procedures, explaining medication, explaining medical costs and insurance issues, and explaining patient care upon discharge from a medical facility (7).

Q: Doesn't this listing of "typical examples" encompass nearly all aspects of a physician's care of a patient?

A: Yes. Physicians might well take exception to such a broad categorization. Most, if not all, physicians' offices use a form for the medical history that is completed by new patients. An interpreter should not be needed if the patient can read the questions and complete the form. If questions arise in regard to the form, either printed instructions or writing notes should suffice to assure adequate communication.

Q: What about obtaining informed consent?

A: The informed consent issue is similar. A physician would not know whether a deaf person had given voluntary informed consent when an interpreter is present unless the physician is aware of what precise information has been communicated

LEGAL NOTEBOOK

Texas Attorney General Advisory Opinions can be requested by agencies of state, county, and local government, and by certain state officials. An opinion provides either advice, a judgment, or decision along with the legal reasons and principles on which it is based. TMA monitors opinion requests and occasionally urges qualified state officials to request an opinion. Briefs addressing requests involving health issues are provided to the attorney general by TMA to assist in formulating appropriate opinions. The following are recent attorney general opinions affecting the medical profession.

- The Texas attorney general was asked whether proposed rules issued by the Texas Optometry Board went beyond statutory authority permitted in recent legislation that established "therapeutic optometrists." The issues were specifically concerned with lists of drugs that a therapeutic optometrist may use and, in the case of an optometrist treating a person under Medicaid, the constitutionality under the Texas Constitution. The TMA Office of General Counsel submitted a brief supporting the position of the Texas Ophthalmological Association arguing that the rules of the optometry board are broad, vague, and violate the legislative intent of the new law. The attorney general's opinion No. DM-152, issued on August 13, 1992, held that the law and rules of the optometry board were neither unconstitutional, ambiguous, nor vague. The law and rule were permitted to stand.

- The Texas attorney general was asked whether a hospital authority may pay physicians a flat fee or per diem to be on call to admit emergency room patients as provided in Section 3.06(f) of the Texas Medical Practice Act without violating 161.091 of the Health and Safety Code. TMA's Office of General Counsel submitted a brief arguing that the arrangement proposed could comply with the Texas illegal remuneration statute if the contract language specifies that payments are not based on a flat fee per patient or type of procedure performed but are based on paying the physicians a minimum guarantee to assure availability. The attorney general's opinion No. DM-138, issued on July 8, 1992, held that payments made under contracts as mentioned above would not be prohibited by 161.091 of the Texas Health and Safety Code.

in sign language by the interpreter. Printed material that the deaf patient could read and sign might provide a better way to document informed consent. Additionally, printed materials would be less subject to interpretation in court if the issue of informed consent were to be litigated. Of course, the physician should be available to answer questions the patient may have and document that fact in the chart.

Q: What about the cost of hiring an interpreter?

A: Prices vary, but in the instances that TMA has been made aware of, the cost of a "qualified interpreter" would be about $45 per hour with a 2-hour minimum charge. In those instances, the patients were covered by Medicaid, for which reimbursement would be in the neighborhood of $25 for an office visit. Such cost would certainly be an "undue burden" in these instances.

Q: But aren't there some times when an interpreter is mandatory?

A: There are certain circumstances in which a qualified sign language interpreter may be preferable to an "alternative auxiliary aid" such as pen and paper or typewriter. These circumstances include psychiatric treatment or other extremely sensitive matters. For example, although a deaf person's family member may very well be able to converse in sign language, the deaf person may not wish to have the family member be privy to matters under discussion. The comments about decisions as to whether major surgery is necessary provide only limited guidance, however.

Q: Is anyone specifically developing guidance about the ADA's impact on health care?

A: The National Rehabilitation Hospital has received a grant from the Department of Justice to develop a program to give assistance to health-care workers in complying with the ADA. The Technical Assistance Program can be reached at (202) 877-1974.

References

1. 42 USCA §12182(b)(2)(a)(iii)(West Pamp 1992).
2. 42 CFR §36.303(c)(1992).
3. 42 CFR §36.303(f)(1992).
4. 56 Fed Reg 355567 (1991).
5. 56 Fed Reg 355566 (1991).
6. 56 Fed Reg 355567 (1991).
7. ADA Communications Accommodations Project; Memorandum on the Obligations of Doctors and Other Health Care Providers Under the Americans with Disabilities Act, reprinted in BJ Anderson: Hearing Disabled Patients under the Americans with Disabilities Act of 1990 (July 9, 1992) (Memorandum to American Society of Medical Association Counsel). ★

Correction

A subhead that appeared in a September 1992 article on posting signs relating to safety, compensation benefits, unemployment, civil rights, and discrimination should have read "Physicians' offices with *15 or more* employees." The article appeared on pages 51–52.

Legal articles in Texas Medicine *are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.*

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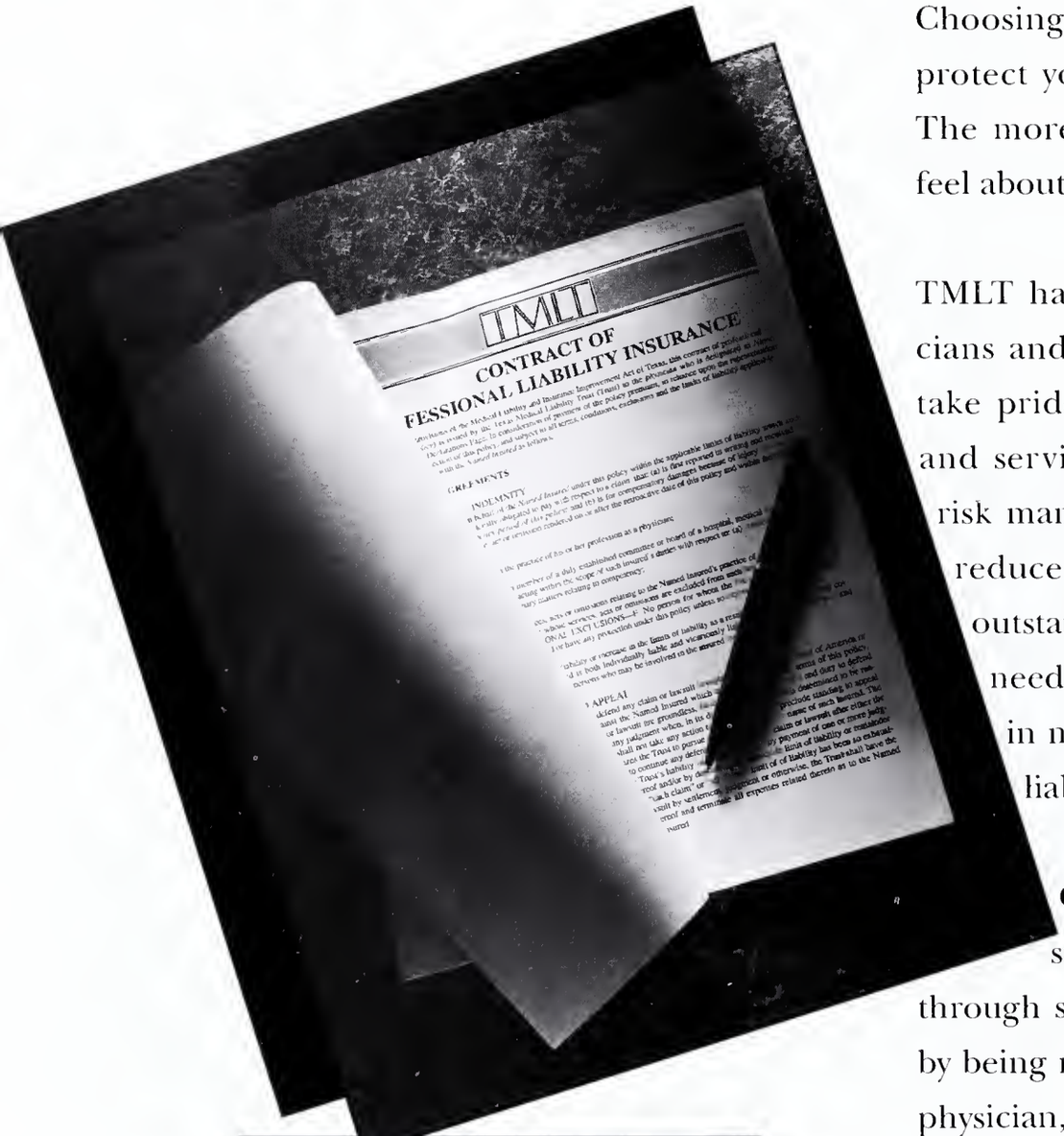

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

Smoking cessation interventions by family physicians in Texas

Jack L. Franklin, PhD
Anna Fay Williams, PhD
G. Michael Kresch
Joseph T. Painter, MD
Karen Torges
Jim White
Owen Grossman, MD

A survey of 1,292 family physicians in Texas indicates that most of them (99%) ask patients about their smoking behavior. Fewer physicians, however, participate in further activities recommended by the National Cancer Institute: arranging follow-up visits, providing self-help materials, prescribing nicotine gum, engaging patients in discussion, referring patients to a program for smoking cessation, and involving other office personnel in counseling. Almost 80% of the respondents cited such obstacles to their involvement in counseling/advising patients as patient attitudes or patient preferences for smoking. The survey was conducted to acquire baseline data on the involvement of family physicians in Texas in counseling their patients who smoke and the obstacles they meet in their efforts.

Dr Franklin, Dr Williams, Mr Kresch, and Dr Painter, The University of Texas M.D. Anderson Cancer Center; Ms Torges, Texas Chapter of the American Cancer Society, Austin, Tex; Mr White and Dr Grossman, Texas Academy of Family Physicians, Austin, Tex. Send reprint requests to Dr Franklin, Director, Health Policy Research and Analysis, Office of the Vice President for Health Policy, M.D. Anderson Cancer Center, 1515 Holcombe Blvd, Houston, TX 77030.

Physicians have contact with approximately 70% of all the smokers in the United States each year (1). Thus, the physician's potential to reduce the prevalence of smoking is high. Furthermore, the physician-patient relationship contains many opportunities for the physician to motivate and to assist the smoker who wants to stop smoking.

The National Cancer Institute and other organizations have urged physicians to follow four steps with patients who smoke (2,3). First, ask about smoking at every opportunity. Second, advise all smokers to stop immediately. Third, assist patients in stopping by helping to set a quitting date, by providing self-help material, by considering a prescription for nicotine gum, and by considering a stop-smoking contract. And fourth, arrange follow-up visits.

Although recommendations call for these practices to be followed routinely, studies indicate that few internists (4) and other physicians (5) use effective strategies such as setting quitting dates or following up with patients who smoke. Even after intensive training in counseling, some physicians discuss smoking with only half of their patients who smoke and infrequently make follow-up appointments to pursue smoking cessation (6,7). Even when physicians do intervene, studies have indicated that they have little confidence in their abilities to help patients change health-threatening behaviors (8).

A survey was conducted during the 1989–1990 winter among family physicians in Texas to provide some baseline data on their experience in counseling with patients who smoke and the obstacles they met in their efforts. These physicians were asked about their adherence to the activities suggested by the Ask/Advise/Assist/Arrange paradigm and the use in their offices of smoking cessation kits. They were asked to describe the obstacles that they perceived in asking about smoking or in counseling/advising their patients who smoke. The paradigm was not mentioned specifically, but several questions dealt with each of the recommended activities. The adherence to these activities was then compared by type of practice, sex, and age of the physicians.

METHODS

A survey form consisting of 1½ pages with a postage-paid return envelope was mailed to 2,558 family physicians, the membership of the Texas Academy of Family Physicians. The cover letter indicated that the survey was conducted under the auspices of the American Cancer Society, The University of Texas M.D. Anderson Cancer Center, and the Texas Academy of Family Physicians. A physician from each of these organizations signed the letter. The letter guaranteed anonymity to the respondents and offered each a copy of the results. As a follow-up with nonrespondents, second copies of the original survey and the cover letter were mailed 2 months after the initial mailing.

The survey, conducted during the 1989–1990 winter, was returned by 1,292 physicians, or 50.5% of the original mailing. The distribution of age, sex, and practice arrangements among the 1,211 physicians who reported them resembles closely the demographics of the sampled population, the membership of the Texas Academy of Family Physicians (Table 1). Information was not

Table 1. Comparison of data from returned surveys to demographics of the Texas Academy of Family Physicians (TAFP).*

	TAFP N=2558	Survey Responses N=1211	Male N=1043	Female N=168
Age (years)				
29 and younger	1.5%	1.1%	1.1%	.0%
30–39	37.8%	36.9%	33.0%	60.7%
40–49	26.4%	26.1%	25.9%	26.2%
50–59	14.9%	14.7%	16.0%	6.5%
60 and older	19.0%	21.3%	23.5%	5.9%
Sex				
Male	88.1%	86.2%		
Female	11.9%	13.8%		
Practice				
Solo	53.0%	49.2%	51.1%	37.3%
Two person	10.0%	9.9%	9.2%	14.5%
Family team	22.0%	21.0%	21.5%	20.5%
Multispecialty	14.0%	10.9%	11.0%	10.2%
Other	0.0%	9.0%	7.2%	17.5%

* Percentages are based on the numbers taken from 1,292 returned surveys where such information was provided.

Table 2. Inquiries about smoking and recording practices by total sample and by sex.

Activities	Total N=1215	Male N=1048‡	Female N=167‡	*P* value
Asks if patients smoke cigarettes	99%	99%	100%	ns*
Asks if patients use other tobacco products	82%	82%	74%	.0158
Puts status on chart	92%	92%	95%	.0003
Uses a note on chart	79%	80%	77%	ns*
Advises/counsels patients who use tobacco products to quit†				
Always	64%	62%	71%	.030
Usually	33%	34%	25%	.018
Sometimes	3%	3%	3%	ns*
Never	0%	0%	0%	ns*

* ns signifies that the difference between male and female physicians does not meet criteria in *t* test for significance ($P<.05$).

† Percentages may not sum to 100 due to rounding.

‡ Column percentages are based on those responding.

available to compare nonrespondents with respondents. The survey included both closed and open-ended questions as well as a Likert-type scale to measure physician involvement in the various activities of the paradigm.

The analysis is based on physicians self-reporting in the survey; no additional observations were made to confirm the accuracy of the responses. Group *t* tests were used to test for the significance of differences in adhering to the activities by practice arrangement (solo versus other practice arrangements), age (younger than 40 years and 40 years and older), and sex. The criterion chosen for judging the significance of the *t* test for differences among the group means was $P<.05$.

SURVEY RESULTS

The responses of 1,292 family physicians in Texas indicate that 27% of their patients smoke cigarettes. Physicians younger than 40 years of age reported a higher percentage of these patients (29%) than did physicians older than 40 years (27%). Estimates of patients who smoke (26%) by physicians in solo practices were slightly lower than those (27%) by physicians in other practices. These percentages are higher than the 22% prevalence rate reported in the 1989 Texas Behavioral Risk Factor Surveillance survey (9).

Physician interventions

Asking about smoking and other tobacco use. Almost all respondents reported that they ask their patients if they smoke cigarettes (99%) and about their use of other tobacco products (82%)(Table 2). We found no significant differences in asking about smoking when we analyzed the data by practice arrangement, age, or sex. Male physicians were more likely to ask about the use of other tobacco products (Table 2), particularly those physicians in solo practice or those who were 40 years and older (data not shown).

Recording tobacco use. Most physicians (92%) reported that they recorded tobacco use in their patients' charts; some (79%), with a note. Those more likely to enter the status on the patients' charts were female physicians (Table 2), physi-

Table 3. Rankings of participation in activities by 1,292 family physicians in Texas.*

	1†	2	3	4	5‡	Missing	Mean
Suggesting specific steps to take reducing or quitting	2%	5%	17%	37%	39%	1%	4.08
Encouraging the patient to set goals	2%	7%	20%	36%	34%	2%	3.92
Presenting pamphlets or other materials	17%	24%	26%	19%	14%	1%	2.88
Prescribing nicotine gum	9%	21%	40%	23%	7%	1%	2.97
Having other office personnel (eg, nurse) counsel	57%	22%	12%	6%	2%	2%	1.74
Referring to a smoking cessation program	28%	31%	25%	10%	5%	1%	2.30
Trying to engage the patient in a discussion about recommendations	5%	9%	27%	34%	24%	1%	3.62
Scheduling a follow-up visit or call about smoking	25%	27%	24%	15%	8%	2%	2.52
Bringing up the subject of smoking at later visits	3%	3%	13%	36%	43%	2%	4.18

* Each row shows the percentage of respondents indicating the column ranking. Percentages may not equal 100% due to rounding.

†1 indicates rarely or never.

‡ 5 indicates all or most of the time.

cians 40 years old and younger, and physicians not in solo practice (data not shown). No significant differences existed by age, sex, or practice arrangement in the use of notes on the charts versus other methods, such as stickers.

Advising patients who smoke to quit. Most (97%) of the physicians always (64%) or usually (33%) advise or counsel their patients who use tobacco to quit (Table 2). Significantly more female physicians (71%) reported that they always advised their patients to quit smoking than did the male physicians (62%). We found no significant differences in the percentages by practice arrangements and by age (data not shown).

Physician involvement in assisting patients in stopping. The physicians rated their efforts in assisting patients in smoking cessation on a five-point rating scale. The intermediate values were not labeled on the survey form. The percentages of physicians responding in each rating level and the means are shown in Table 3. Those activities with the highest mean ratings were suggesting specific steps, encouraging the patient to set goals, engaging the patient in discussion, and bringing up the subject of smoking at later visits. Those activities with the lowest mean ratings were presenting pamphlets or other materials, prescribing nicotine gum, referring patient to a smoking cessation program, scheduling a follow-up visit or call about smoking, and having other office personnel counsel.

By practice arrangements, significant differences existed in physician adherence (data not shown). Physicians in solo practice considered themselves more active than other practitioners in suggesting specific steps for their patients to take (P=.0522), encouraging patients to set goals (P=.0053); presenting them with pamphlets or other self-help materials (P=.0304), and prescribing nicotine gum (P=.0170). They did not differ significantly from other practitioners in their use of smoking cessation programs or in using other office personnel to counsel.

Age of the physician appeared to have little impact on most activities except that those physicians younger than 40 years were more likely to engage patients in discussions about their recommendations (P=.0573) or to schedule a follow-up visit (P=.0081). Female physicians were more likely to engage patients in discussions (P=.0046), prescribe nicotine gum (P=.0361), and refer their patients to smoking cessation programs (P=.001).

Use of office-based smoking cessation kits. Only 13% of the physicians indicated that they had used smoking cessation kits in their offices (data not shown). We found no significant differences by sex, age, or practice arrangements in the use of such kits. Only 20% of all respondents were able to name pamphlets that they provided to their patients.

Results of counseling. Physicians reported that 22% of the patients they counseled about smoking made significant changes as defined by the reporting physicians (data not shown). We found no significant differences among groups by age and sex, but physicians in solo practice reported that more of their patients (22%) had made significant changes than had the patients of those in other practices (19%).

Perceived obstacles

In several open-ended questions, physicians were asked about the obstacles they faced in asking or in counseling/advising their patients about smoking.

Obstacles to asking. When asked to identify primary obstacles in asking their patients if they smoke, 34% reported that no obstacles existed and 20% did not answer the open-ended question (data not shown), while 46% indicated some obstacles. Among those mentioning obstacles, the two most frequently cited were that the patient has no desire to quit (13%) and that the patient becomes defensive (13%). We found no significant differences by sex, age, or practice arrangements.

Obstacles to counseling. Obstacles to counseling were cited by about 80% of those responding to the open-ended question. The major obstacle to counseling cited by about 25% was that the patient enjoyed smoking or had no desire to quit (data not shown). About 18% of those responding to the question cited obstacles involving patient attitudes: patients were stubborn, had a poor attitude, were hopeless, and had no willpower or motivation. No significant differences existed by age, sex, or practice arrangement among those who mentioned obstacles to counseling.

DISCUSSION

The results from those Texas physicians participating in the survey suggest that most physicians ask their patients about smoking. Most seem aware of the recommendations in the Ask/Advise/Assist/Arrange paradigm. These physicians appear to favor those activities that can be carried out in direct conversation with the patient in a relatively short time. Few physicians indicated conducting additional activities that involved other personnel or additional smoking cessation aids to assist their patients who smoke in quitting. This result is consistent with other national and state studies (4,8).

This survey indicates also the need for more focused research to answer the question: What are the minimal interventions by physicians that help a patient stop smoking? On the basis of their own evaluations, family physicians in Texas are having an impact on smoking cessation, even with minimal activities. Those responding indicated that one fifth of the patients counseled made significant changes in their smoking behavior.

At the national level, other trials by the National Cancer Institute found that physicians can be effective (10,11). Intervention by physicians was cited as one of the most successful methods of cessation, with a mean success rate of 23% in 1-year cessation after an intervention (12). Even minimal intervention by physicians can be helpful to the extent that advice from general practitioners delivered to healthy patients has resulted in 1-year quitting rates of about 5% to 10% (13). Unfortunately, further comparisons cannot be made with this study since a definition of what constitutes a significant change in behavior was not included in the Texas data-gathering instrument. Future studies should incorporate some measurements such as the period of time in which a patient abstained, a reduction in the number of cigarettes smoked, or the numbers of times that a patient smoked before and after counseling.

Perceptions of the patient's attitudes about smoking become obstacles that discourage physicians from continuing to assist patients in their efforts to stop smoking. Physicians may also feel that patients are not receptive to counseling about personal health behaviors (14). While the reactions of physicians in our survey to patients' attitudes may not be surprising, they do suggest a need to strengthen the efforts of family physicians toward smoking cessation with continuing medical education in behavioral modification for patients. Further study of the practice styles by sex and age groups may also provide information that would be helpful to determine what counseling/advising approaches are effective with these different groups of physicians.

These results appear to corroborate the recommendations of other researchers that present-day physicians would benefit greatly from practical step-by-step guidelines for brief office-based counseling and from information that would enable them to direct patients to state-of-the-art self-help materials and community treatment programs. Furthermore, physicians would benefit from self-help materials for their patients and from training in health-promotion tactics for their support personnel (8).

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Dicyclomine for medical management of persistent anal fissure with associated spasm of the internal sphincter

Lucinda G. Miller, PharmD, BCPS
John C. Rogers, MD, MPH
Ervin B. Brown, MD, FACS
Gayle Perkins, PA

The case of a 43-year-old woman with persistent anal fissure responsive to dicyclomine is described. Associated spasm of the internal sphincter had precluded fissure healing. The spasm of the internal sphincter relaxed within 24 hours of dicyclomine administration and subsequently allowed healing. Surgery was avoided.

Dr Miller, assistant professor, and Dr Rogers, associate professor, Department of Family Medicine, Baylor College of Medicine, Houston, Tex; Dr Brown, private practice, Houston, Tex; Ms Perkins, private practice, Kimball, Neb. Send reprint requests to Dr Miller, 5510 Greenbriar Rd, Houston, TX 77005.

Dicyclomine is an anticholinergic medication with nonspecific direct relaxant action on smooth muscle (1). This drug can decrease spasm of the gastrointestinal tract, biliary tract, ureter, and uterus without producing concomitant anticholinergic effects on the cardiovascular system, eye, or salivary, sweat or gastrointestinal glands. Because of these properties, dicyclomine has been used to treat disturbances of gastrointestinal motility including irritable bowel syndrome and acute enterocolitis (2). In this report, we describe dicyclomine's apparent effectiveness in treating internal sphincter spasm and promoting healing of an anal fissure.

CASE REPORT

A 43-year-old white woman presented with a 3-week history of rectal pain that began after 2 months of a commercial weight-reducing diet that caused constipation. She developed an anal fissure that did not respond to topical hydrocortisone, pramoxine/benzyl benzoate/balsam Peru/zinc oxide/mineral oil ointment (Anusol^R), docusate sodium (Colace^R), or sitz baths. She also applied lidocaine (Xylocaine^R) 2.5% ointment twice daily for the 4 days preceding her first examination without relief. The patient continued to experience considerable internal sphincter spasm that kept the lesion from healing. The fissure pain and secondary severe spasm of the external sphincter became so severe that the patient could not sit for any extended period of time.

Examination revealed significant spasm of the external sphincter, one nonthrombosed hemorrhoid, and the persistent anal fissure. Anoscopy was impossible because of pain and spasm. Lidocaine 5% ointment was applied locally and acetaminophen with codeine (30 mg) was prescribed. A trial of dicyclomine in doses of 10 to 20 mg 3 times a day was started to relieve spasm until the patient could see a general surgeon for consultation the following day. The surgeon noted a posterior anal fissure and an unexpectedly relaxed internal sphincter. The rectal examination was completed without undue discomfort. The potential benefit of a lateral sphincterotomy was discussed, but the patient elected to continue medical management with dicyclomine and docusate. The pain dramatically improved after 2 days of dicyclomine and completely resolved after 2 to 3 more days of "as needed" medication. At follow-up 2 months later, the patient remained pain free without any further treatment.

DISCUSSION

An anal fissure is a small tear (rarely larger than 1 cm) in the squamous mucosa, usually at the posterior or anterior commissure of the anal canal. Pain during and for as long as several hours after bowel movements and bright red blood on the toilet tissue are characteristic. Pain may cause intense external sphincter spasm, making digital rectal examination impossible. When serious underlying causes are not present, two thirds of cases heal with conservative treatment consisting of anal hygiene, sitz baths, and bulk-producing agents. Adding local anesthetic jelly diminishes pain and abolishes any exaggerated anal reflex that causes intense external sphincter spasm. Once the fissure becomes chronic, a lateral sphincterotomy, dividing the lower half of the inter-

nal sphincter, is usually required and nearly always cures the condition. A fissurectomy is indicated occasionally (3–5).

Dicyclomine is a muscarinic receptor antagonist with high affinity for neuronal (M_1) muscarinic receptors, intermediate affinity for glandular receptors, and low affinity for cardiac receptors (6). This heterogeneity among muscarinic receptor subtypes and dicyclomine's preferential effect on the various receptor subtypes translate into an effective antispasmodic agent for smooth muscle that minimizes anticholinergic side effects elsewhere, such as the eye or cardiovascular system (7). While no literature published to date discusses the use of dicyclomine in the treatment of internal anal sphincter spasm, this case report indicates its potential effectiveness.

In this case, internal rectal sphincter spasm precluded healing of an anal fissure. Application of lidocaine 2.5% ointment was unsuccessful in diminishing the pain and spasm. Dicyclomine relieved the spasm of the smooth muscle of the internal sphincter, allowing healing to occur. Had the dicyclomine been ineffective and the anal fissure persisted, a lateral sphincterotomy would have been indicated.

Medical management of anal fissure with associated internal sphincter spasm with dicyclomine may represent a noninvasive intervention for this condition that may allow some patients to avoid or delay surgery. Study of its use in a controlled setting with a large number of patients may be warranted.

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Medical Specialist — Rusk State Hospital has opening for a Medical Doctor to provide limited general adult medical services to patients in a state psychiatric hospital. Forty-hour regular duty work week (Monday–Friday; 8 am–5 pm). Rusk is located in the beautiful piney woods of East Texas. Very favorable cost of living, particularly regarding real estate. Excellent recreational opportunities abound. Requires residency (3 yr) trained BE/BC physician. Must have completed accredited 3-year residency in internal medicine or family medicine. Salary $9,228–$10,935 monthly, DOQ. Contact Rusk State Hospital Human Resources Office, PO Box 318, Rusk, TX 75785. 903-683-3421, ext 3270. EEO/AA Employer.

Family Practice Physician for North Central Texas community. Associate with board-certified physicians — modern clinic building — 70-bed hospital. Salary guarantee — $120,000. Obstetrics not required. Contact: Stan Schuermann, 800-332-8663.

Southwest Houston — Full or part-time opportunity for family physician. Flexible hours; hospital responsibilities optional. $100,000+ per year including salary and benefits. Please send CV to Gregg Barfield, PO Box 10801, College Station, TX 77842, or call 409-696-6388 for more information.

San Antonio, Texas — FP and IMs. Several opportunities available including hospital-sponsored solo, multispecialty, single specialty, and ambulatory care. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911 or 713-531-0911.

Orlando, Florida — Clinic expansion requires addition of 4 FPs. Competitive compensation packages. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911.

Ambulatory Care — Opportunities available in Alabama, Georgia, Mississippi, Texas, and Florida. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911.

General Surgery

San Antonio — General/Vascular surgeon wanted for hospital staff position. Private practice and academic affiliation available. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911.

Internal Medicine

Fort Worth, Texas
BE/BC Internist -- American Trained -- Stable 10 MD Group -- Adding 7th Internist -- Downtown location -- Salary + Bonus + Paid Expenses -- Fee for service practice -- Mail CV: Administrator, The Fort Worth Clinic, 1221 West Lancaster Avenue, Fort Worth, TX 76102

Gold Mine for Internist — Wanted, aggressive and energetic physician, BE/BC to do consultations for a group of family physicians. Must be able to do procedures. Very competitive fee for service income available, including benefits. Salary is based on percentage of collections with a base salary guarantee. Send CV to Nancy Bloomfield, 4010 College St, Suite 200, Beaumont, TX 77707.

Texas — over 160 opportunities in FP, IM, and IM subspecialties. Metro, suburban, and rural locations. Guarantees range form $90,000–$150,000. For details, contact Practice Dynamics, 11222 Richmond, Ste 125, Houston, TX, 77082; 800-933-0911 or 713-531-0911.

Dallas — BC/BE General Internist to join well-trained, respected internists in group practice at Presbyterian Hospital, a tertiary care teaching hospital. Beautiful new office. Salary and full benefits paid. Send CV to Internal Medicine Healthcare Associates, 8230 Walnut Hill #212, Dallas, TX 75231.

Internal Medicine — Expanding 14-physician internal medicine clinic with 58 years of service in Texas state capital is seeking an internal medicine specialist. We offer a competitive compensation and benefits package, leading to full partnership. Austin offers excellent lifestyle, major university, scenic hill country, lakes, and abundant recreational opportunities. Please submit curriculum vitae to John Guzzino, Administrator, 601 Medical Park Tower, Austin, TX 78705.

Immediate Need — Internist, MD, B/C with additional training in infectious diseases or pulmonary medicine helpful, but not required. Hospital-based practice, with broad spectrum of cases and special emphasis on tuberculosis and pulmonary diseases. Spanish speaking helpful, but not required. Regular work schedule, limited call, and liberal state salary. Tax-sheltered benefits, vacations, and retirement, as well as educational opportunities. San Antonio State Chest Hospital, 2303 S.E. Military Drive, San Antonio, TX 78223. Call 512-534-8857, ext 255; Louis Hinojosa, Jr, Dir. H.R. An Equal Employment Opportunity Employer.

Don't suffer brokers or move to the boonies! Busy DFW pediatric practice desires internist to locate adjacent/treat parents and older siblings in growing, high-income neighborhood. Contact Ad Box 804, 401 West 15th Street, Austin, TX 78701.

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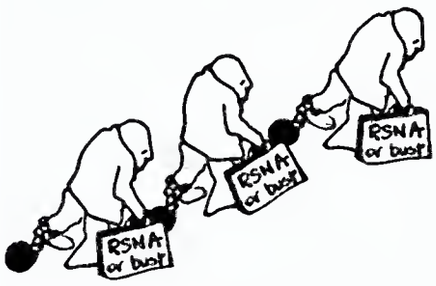
Primary Care

Primary Care, Huntsville — Hospital-Sponsored Rural Health Clinic. No nights, weekends, or call. Salary negotiable. Send CV or call Medical Staff Coordinator, Huntsville Memorial Hospital, PO Box 4001, Huntsville, TX 77342-4001; 409-291-4512.

Radiology

It's time for R & R.



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FAMILY PRACTICE

CENTRAL TEXAS
Established group of young FPs and well-equipped, financially sound, JCAHO-accredited hospital seek two BC FPs to accommodate increasing patient volume. Full scope of family medicine. Shared call and competitive incentive package to qualified doctor. Major lake, 18-hole golf course. Contact: Barry Strittmatter.

SOUTH CENTRAL TEXAS
Within one hour of San Antonio - South Central Texas hospital seeks additional BE/BC family practitioner for service area of 20,000. OB is available, but not required. Hunting and fishing (fresh and salt water) and other recreational activities abound. Generous incentive package to qualified candidate.
Contact: Barry Strittmatter.

NORTH CENTRAL TEXAS
Family physicians needed. Practice with established primary care group, or independently with shared call. No OB. Interest in pediatrics a plus. Attractive, well-equipped, 56-bed hospital. Competitive incentive package. Contact: Jim Truitt.

NORTH CENTRAL TEXAS
Popular location, recreational paradise! Need two more FPs to offer full range of family medicine in town of 21,000; easy access to Dallas/Fort Worth. OB optional. Ultra-modern, 200-bed hospital. Excellent referral base and backup. Generous incentive package. This opportunity has it all! Contact: Vicki Truitt.

EAST TEXAS
A financially sound, 48-bed hospital seeks board certified (or eligible pursuing certification) family physician to establish a solo practice. Call sharing and coverage is available from other family physicians in the community. This beautiful rural community is a recreational mecca; hunting, fishing, water sports, camping, etc. Competitive incentive package to qualified physician. Contact: Barry Strittmatter.

EAST TEXAS
Two board certified, recently trained family physicians are seeking additional family physician for associate practice (or solo sharing call) in small university town within one hour of D/FW Metroplex. No OB. Great life style among sophisticated population without the hassles of, but access to, a large city. Lots of recreational and social amenities. Generous incentive package from community hospital to qualified doctor.
Contact: Barry Strittmatter.

EL PASO
A highly respected and well-established physician in El Paso (population approximately 500,000), wishes to retire. He and the hospital with whom he is associated seek a board certified (or board eligible pursuing certification) family physician to join him and begin to assume his large practice. Competitive benefit package to qualified candidate. Contact: Barry Strittmatter.

FORT WORTH
Family physician needed to deliver basic primary care in "fast track" unit of busy ER. The regular hours of this position will allow you to enjoy a nice lifestyle in a city with tremendous amenities. Salaried position. Call us for details. Contact: Vicki Truitt

FORT WORTH
Largest family practice residency program in the country seeks division director to coordinate faculty development, (clinical) research and grant activities. Position encompasses teaching, patient care and administrative responsibilities. Prefer physician with rural practice experience; board certification required. Clinical assistant professorship appointment to major medical school; good income and benefits; little to no call. Join the team and enjoy your profession!
Contact: Vicki Truitt.

INTERNAL MEDICINE

NORTH CENTRAL TEXAS
Popular location, great lifestyle. Three busy internists seek fourth to join practice. Excellent hospital facilities and equipment. Outstanding referral base and backup. Community of 21,000 with easy access to Dallas/Fort Worth. Recreational opportunities abound - and the coverage will allow you time to enjoy it! Generous incentive package. Contact: Vicki Truitt.

D/FW METROPLEX
BC internist needed to fill the position of Director, Department of Internal Medicine of major teaching hospital. Individual selected must possess strong administrative skills, be an effective communicator, committed to primary care medicine, dedicated to quality medical education and willing to provide some direct patient care. Five day work week, superb income, benefits and UT faculty appointment will be offered to qualified individual. Contact: Jim Truitt.

SOUTH TEXAS
Thirty minutes from Padre Island. IM group, specializing in critical care, seeks third compatible associate. Great climate and lifestyle. Recreational opportunities abound. Guaranteed income with high monetary potential. Contact: Barry Strittmatter.

FORT WORTH
BC internist needed to see patients in general medicine clinics and accommodate IM consultations in community based health clinics. Five-day work week, regular hours. Superb income and benefits. Great opportunity for interesting practice and excellent life style.
Contact: Jim Truitt.

OBSTETRICS/GYNECOLOGY

NORTHEAST TEXAS
Regional medical center serving 200,000 seeks BE/BC OB/GYN for private practice (to share call with three other OB/GYNs). Can accommodate two who wish to practice together. Progressive, family-oriented community with strong diversified economy; excellent schools. Many social and recreational opportunities. Comprehensive incentive package to qualified physician. Contact: Vicki Truitt.

NORTH CENTRAL TEXAS
BE/BC OB/GYN needed for associate practice in north central Texas community of approximately 21,000 (serving referral area of 206,000). Regional medical center with ultra-modern OB facilities and equipment. Good neonatal support. Area renown for recreational facilities. Easy acess to Dallas/Fort Worth metropolitan area. Contact: Vicki Truitt.

ONCOLOGY

FORT WORTH
Full time medical oncologist needed at teaching hospital in D/FW Metroplex, clinical teaching appointment to UT medical school. Manage oncology division, develop full time oncology teaching service. Utilize modern facilities; infusion lab. Regular hours and limited call. Attractive income and benefits. Contact: Jim Truitt.

PEDIATRICS

NORTH CENTRAL TEXAS
Recently trained, BC female pediatrician seeks compatible associate for private practice. Four-way shared call; superb hospital facilities; Level II nursery. Competitive income and benefits. Attractive area with easy access to Dallas/Fort Worth. Contact: Vicki Truitt.

SOUTH TEXAS
Pediatric group practice. Three American-trained, board certified pediatricians seek compatible associate to join rapidly growing practice in the Rio Grande Valley. Excellent income potential in an area acclaimed for its great climate and recreational opportunities.
Contact: Barry Strittmatter.

NORTHEAST TEXAS
Dynamic group of American trained, BC pediatricians seek fourth associate for group practice in attractive community of 27,000 (referral area of 200,000). Progressive, family-oriented community with strong, diversified economy; excellent schools. Social and recreational opportunities abound. Modern hospital with Level II nursery and designated pediatric care unit. Shared call; excellent income and benefits; early partnership. Contact: Vicki Truitt.

PULMONARY MEDICINE

FORT WORTH
Immediate need for fellowship trained pulmonary medicine specialist to accommodate full time, 100% pulmonary and critical care consultative service. Teaching hospital, resident supervision. Limited weekend and evening call responsibility; coverage available from BC pulmonologist. Great opportunity for interesting practice with excellent life style. Good income and benefits. Contact: Jim Truitt.

■ Physician Search & Placement
■ Medical Practice Appraisal, Brokerage & Management Consulting

Physician Resource Network

1342 Johnson Road
Keller, Texas 76248

1-800-525-6055 / (817)431-9679
Metro (817) 379-5727
FAX (817) 431-2317

Endorsed by the Texas Medical Association

Please call for additional listings.

Expanding 15-Physician multispecialty group has excellent opportunity for a radiologist in friendly West Texas community of 25,000. Adjacent to a 153-bed modern hospital. Excellent guaranteed salary with no first year expenses in addition to benefits. Moving allowance also available. Direct inquiries or send CV to Gail Knous, Malone & Hogan Clinic, 1501 W 11th Place, Big Spring, TX 79720; 915-267-6361.

Diagnostic Radiologist with CT, MR, Interventional, US, Nuclear Medicine skills to join group of seven Board Certified Radiologists. Two hospitals, private offices, service to nearby communities. Centrally located to San Antonio, Austin, Houston, Corpus Christi. Good family environment. Contact James Neumann, MD, Box 3610, Victoria, TX 77903; 512-578-0317.

Other Opportunities

PRIVATE PRACTICE OPPORTUNITIES
(in all specialties)
Texas & Sunbelt States
Call 1-800-284-4560 / Houston 713-785-3722
Or send CV to:
PO Box 42314
Houston, TX 77242-2314
FAX 713-784-9260
Reuben Bronstein & Associates

Position Available — Seeking BC/BE Family Practice, General Internist, Endocrinologist, OB/GYN to join established multispecialty clinic. Excellent benefits and guarantee. Send CV to Leroy W. Kitch, Administrator, Skinner Clinic, 124 Dallas St, San Antonio, TX 78205.

Correctional Healthcare
Full time primary care Physicians & Psychiatrists, statewide adult correctional facility locations, new **salary increases effective 3/1/92/** benefits/Physician student repayment program. Inquiries: TDJC, Box 99, Personnel Annex, Huntsville, TX 77342-0099 or contact Glynda Baker, **(409) 291-4020.**

FOR SALE OR LEASE

Medical Equipment

For Sale — Solo family practice office equipment, by owner. Most items lightly used and about 5 years old to almost new. XMA x-ray with auto-exposure and compact under table generator, auto processor, Ritter power table, liquid N2 cryotherapy tank and spray gun, autoclave, scales, cast cutter (new), exam tables, microscope, much more. Save money! Dallas. 214-406-1443.

For Sale — Siemens Low Dose Mammography Unit. Mammomat-B. Excellent for diagnostic and screening mammography. Minimal use, excellent value at $18,500. Call Dr Roger Maupin, 512-398-9880, or write to PO Box 907, Lockhart, TX 78644.

For Sale — Complete turnkey office XMA X-ray System, low prior usage, installation and onsite instruction for office staff, includes QX70 processor and accessories. Contact 817-759-4298.

Office Space

For rent or lease in Amarillo, Tx. Medical office 2000+ square feet. Six exam rooms, lots of storage, and telephone system. Next to established pharmacy — very reasonable. Contact Phil Durham or Ray Doherty at 806-383-3377.

For Sale — Medical science center office at 711 West 38th, Austin, Texas. Approximately 1,170 square feet. $129,900. Contact Clarke Witt, MD, at 817-481-0012.

Practices

Selling Your Practice? We offer practice evaluations & brokerage, physician recruiting, and partnership buy-in services. We can help you make the right decisions. For a free brochure, call or write: PRACTICE DYNAMICS, Dept T, 11222 Richmond, Ste 125, Houston, TX 77082; 713-531-0911.

Houston — Quality practice with excellent medical reputation. Large patient base. Doctor retiring, will stay for transition. Located just outside metroplex. Contact Business & Professional Associates 713-782-8888. TDH1402.

Suburban Metroplex — Well established General Surgery practice available. Collections in excess of $330,000 for 1991. Prestigiously located office is fully computerized. Thorough and generous introduction. Courteous and efficient staff will stay, if desired. For information, confidentially contact AD Box 803, 401 West 15th Street, Austin, TX 78701.

For Sale — Family Practice (expense shared with another FP), suburban DFW metroplex, available January 1993. Annual gross exceeds $300,000. Call 817-795-2550, evenings.

BUSINESS AND FINANCIAL SERVICES

Physician's signature loans to $50,000. Up to seven years to repay. No prepayment penalties. Prompt, courteous service. Competitive fixed rate. Physicians Service Association, Atlanta, Georgia. Toll Free 1-800-241-6905. Serving MDs for over 10 years.

Physicians and Surgeons needed for medical legal consulting work in Texas and other states. Excellent compensation. Extremely interesting work. All replies confidential. Medicomm Consultants, Inc. 719-473-9432.

Advertising Rates & Data — Regular classified advertising sells for $2.00 per word, minimum 25 words or $50, per issue. We do not count articles (a, an, the). Display classified advertising sells for $95 per column inch, per month. A variety of typefaces, logos, and borders may be used in display classified ads. Ad box numbers can be substituted for formal addresses upon request at no extra cost. Name and address of ad box number listings cannot be given out unless specific permission to do so has been given. The advertising office will not contact ad box number holders except by mail. Federal laws prohibit references to race, color, religion, sex, natural origin, or age unless bona fide occupational qualifications. Copy deadline is the **1st** of the month preceding publication. Send copy to Shari Henson, Classified Manager, TEXAS MEDICINE, 401 West 15th, Austin, Texas 78701.

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Publication of an advertisement in **Texas Medicine** is not to be considered an endorsement or approval by the Texas Medical Association of the product or the service involved.

Statement of Ownership, Management and Circulation

(Required by 39 U.S.C. 3685)

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401 West 15th Street, Austin, Travis, Texas 78701-1680

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401 West 15th Street, Austin, Travis, Texas 78701-1680

6. Full Names and Complete Mailing Address of Publisher, Editor, and Managing Editor ***(This item MUST NOT be blank)***

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Kathryn Trombatore, 401 West 15th Street, Austin, Texas 78701-1680

7. Owner *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Item must be completed.)*

Full Name	Complete Mailing Address
Texas Medical Association	401 West 15th Street, Austin, TX 78701-1680

8. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages or Other Securities *(If there are none, so state)*

Full Name	Complete Mailing Address
None	

9. For Completion by Nonprofit Organizations Authorized To Mail at Special Rates *(DMM Section 424.12 only)*
The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes *(Check one)*

(1) [X] Has Not Changed During Preceding 12 Months
(2) [ ] Has Changed During Preceding 12 Months

(If changed, publisher must submit explanation of change with this statement.)

10. Extent and Nature of Circulation *(See instructions on reverse side)*	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
A. Total No. Copies *(Net Press Run)*	30,102	30,665
B. Paid and/or Requested Circulation 1. Sales through dealers and carriers, street vendors and counter sales	0	0
2. Mail Subscription *(Paid and/or requested)*	25,111	25,315
C. Total Paid and/or Requested Circulation *(Sum of 10B1 and 10B2)*	25,111	25,315
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies	4,141	4,650
E. Total Distribution *(Sum of C and D)*	29,252	29,965
F. Copies Not Distributed 1. Office use, left over, unaccounted, spoiled after printing	850	700
2. Return from News Agents	0	0
G. TOTAL *(Sum of E, F1 and 2—should equal net press run shown in A)*	30,102	30,665

11. **I certify that the statements made by me above are correct and complete**

Signature and Title of Editor, Publisher, Business Manager, or Owner

Kathryn Trombatore Managing Editor

(See instructions on reverse)

PS Form **3526**, January 1991

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The Scott & White Clinic, a multispecialty clinic of 350 physicians, has several opportunities for general internists.

One internist is needed to join the growing 8-physician staff in its Taylor facility. The Taylor community has a population of 11,000 and is located north of Austin.

An internist is needed for the clinic in College Station. This multispecialty clinic has 30 staff members, including 4 internists. Bryan/College Station is the home of Texas A&M University and has a 100,000 population.

The Gatesville Clinic also needs an internist to join its 10 physician staff. Gatesville has a population of 7,000.

Scott & White offers an excellent benefit and salary package. Excellent educational opportunities. Medical school affiliation available.

Send CV to:

Physician Recruitment
Scott & White
2401 South 31st Street
Temple, TX 76508

For more information, please call (817) 774-5650 or (800) 725-3627.

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VISA MasterCard

For more professional advertising information call **Texas Medical Association Advertising Department** at (512) 370-1384 FAX (512) 370-1632

CME / Continuing Education Directory

Courses

DECEMBER

Cardiology

Dec 6–9, 1992
Williamsburg Conference on Heart Disease. Williamsburg, Va. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Dec 7–9, 1992
Major Topics in Cardiology Today & Progress Toward the Turn of the Century. New York. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Dec 12, 1992
Management of Hypercholesterolemia: Goals and Strategies. St Louis. Contact Washington University School of Medicine, Campus Box 8063, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Gastroenterology

Dec 4–5, 1992
Gastroenterology for the Primary Care Physician. San Antonio. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Gynecologic Surgery

Dec 11–12, 1992
Endoscopic Stapling for the Practicing Gynecologist. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Obstetrics and Gynecology

Dec 4–6, 1992
The Specialist in Obstetrics & Gynecology and Primary Care for Women. Dallas. Contact Southwestern Gynecologic Assembly, 7777 Forest Ln, Bldg C, #204, Dallas, TX 75230 (214) 661-4660

Oncology

Dec 5, 1992
Laparoscopy & Thoracoscopy in Cancer Management. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Pediatrics

Dec 11, 1992
Pediatric Urology: Management Update. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Psychiatry

Dec 4–5, 1992
Hospital Psychiatry in the Year 2000. Houston. Contact The University of Texas Medical School at Houston, PO Box 20367, DCT S130, Houston, TX 77225 (713) 792-5346

Risk Management

Dec 5, 1992
Grand Rounds in Medical Malpractice. San Antonio. Contact Medical Risk Management, Inc, 2500 City West Blvd, Ste 300, Houston, TX 77042 (713) 789-6518

JANUARY

Cardiology

Jan 11–15, 1993
Cardiology Conference at Snowmass. Snowmass, Colo. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Jan 21–22, 1993
Introduction to Mitral Valve Repair. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Jan 24–26, 1993
Congenital Heart Disease in the Adult. San Diego. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Jan 29–31, 1993
New Diagnostic & Therapeutic Techniques in Clinical Cardiology. Lake Buena Vista, Fla. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Gynecologic Surgery

Jan 16, 1993
Flexible Office Hysteroscopy. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Orthopedic Surgery

Jan 15–17, 1993
Southwestern Orthopaedic Recertification. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Psychiatry

Jan 16, 1993
Biological Basis of Mechanics Underlying Bipolar Disorder. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Infectious Diseases

Jan 14–17, 1993
Infectious Diseases Update for the Primary Care Physician. Lake Tahoe, Nev. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Obstetrics and Gynecology

Jan 21–23, 1993
Diseases of the Vulva and Vagina. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Jan 22–23, 1993
Breast Disease 1993. Houston. Contact The University of Texas Medical School at Houston, Office of CME, 1100 Holcombe Blvd, HMB 15.1509, Houston, TX 77030 (713) 792-5346

Oncology

Jan 30, 1993
Cancer Update on Melanoma/Sarcoma. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

FEBRUARY

Cardiology

Feb 10–13, 1993
Cardiovascular Conference at Snowbird. Snowbird, Utah. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Gastroenterology

Feb 19–20, 1993
Advances in Gastroenterology. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

Neurology

Feb 11–13, 1993
Recent Advances in Neurology. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Oncology

Feb 12–13, 1993
Clinical Implications of Prostate Cancer Biology. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Pathology

Feb 11–14, 1993
Cytopathology Review Course. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Psychiatry

Feb 27, 1993
Geriatric Psychiatry Review. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

MARCH

Audiology

Mar 12, 1993
Audiology Conference. College Station. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Critical Care

Mar 6–11, 1993
Critical Care Medicine Course. Oklahoma City. Contact Oklahoma University Health Science Center, Dept of Medicine, Rm 3SP 400, PO Box 26901, Oklahoma City, OK 73190 (405) 271-5904

Emergency Medicine

Mar 12–13, 1993
Annual Emergency Medicine Review. Austin. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Obstetrics and Gynecology

Mar 17–20, 1993
Controversies in Female Issues & Endocrinology. Puerto Vallarta, Mexico. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Orthopedic Surgery

Mar 10–14, 1993
Texas Orthopaedic Surgery Workshop. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

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Mar 20–21, 1993
Endoscopic Sinus Surgery. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

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Mar 15–25, 1993
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Mar 6–9, 1993
Dallas Rhinoplasty Symposium. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Psychiatry

Mar 13, 1993
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From Deposition to Courtroom
Dec 3, 1992, Abilene

Carcinoma of the Breast
Dec 2, 1992, Austin

Calendar of Meetings

• Denotes Texas meeting

November

Nov 1–2, 1992, Phoenix
Leukemia Society of America Symposium
Contact LSA, 733 Third Ave, New York, NY 10017 (212) 573-8484, ext 138

Nov 5–8, 1992, St Louis
International Society for Applied Cardiovascular Biology 3rd Biennial Meeting
Contact Washington University School of Medicine, Campus Box 8063, 660 S Euclid Ave, St Louis, MO 63110-1093 (800) 325-9862

Nov 12–14, 1992, El Paso
•*Southwest Association of Hispanic American Physicians Annual Medical Congress*
Contact SWAHAP, 2626 N Mesa #121, El Paso, TX 79902 (915) 532-9494

Nov 18–21, 1992, Houston
•*American Association for Cancer Education*
Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Nov 20–21, 1992, Austin
•Texas Medical Association House of Delegates Interim Session
Contact Sharon Walker (House of Delegates) or Mrs Dale Willimack (meeting fa-

cilities and housing), TMA, 401 W 15th St, Austin, TX 78701 (800) 880-1300 or (512) 370-1300

Nov 27–Dec 4, Chicago
Radiological Society of North America Annual Meeting & Scientific Assembly
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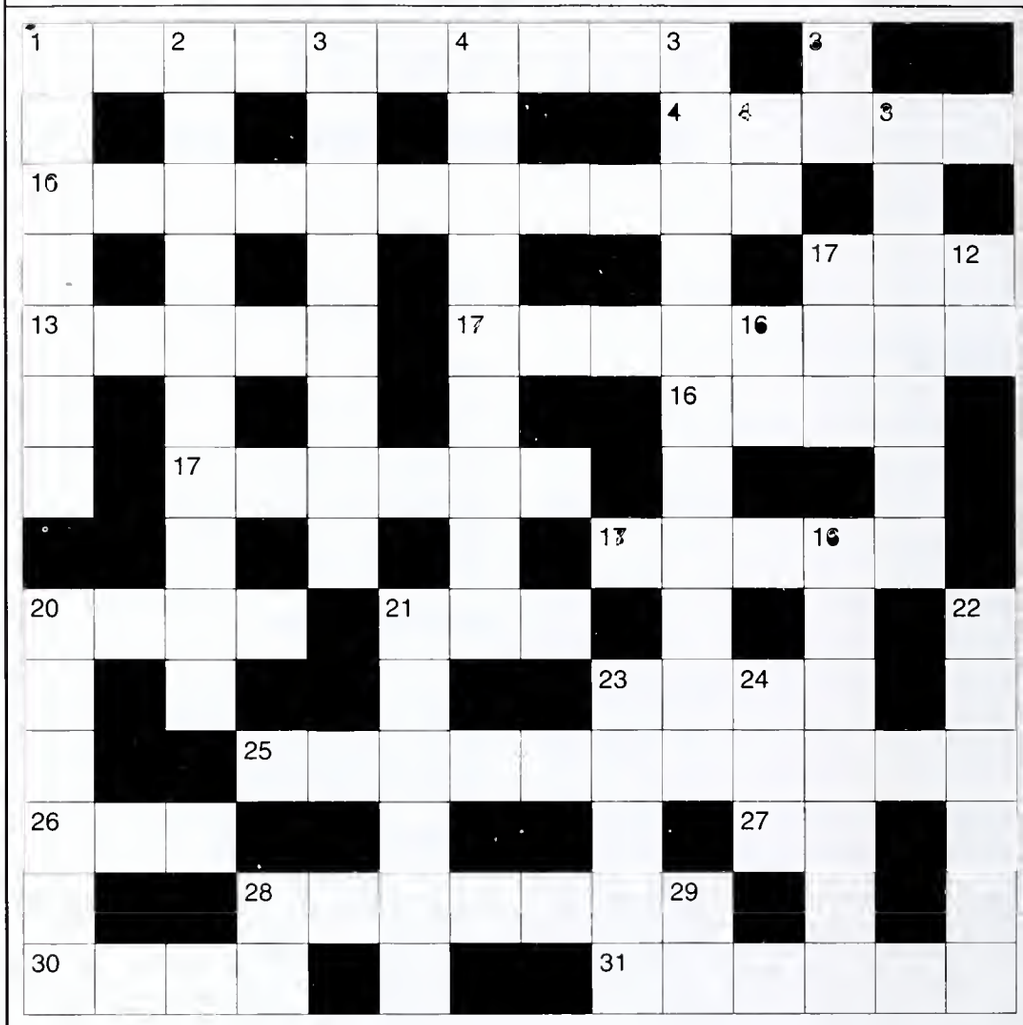

ACROSS

1. Increased density of bone following inflammation (10)
7. Compound formed by the combination of an acid and an alcohol (5)
10. Occurring suddenly and without force (11)
11. Records cerebral function, initials (3)
13 and 25 Across. Pertaining to the atrium and ventricle (5,11)
14. Minor disorder of pregnancy (8)
16. A minute circular opening on a surface (4)
17. A ring of pigmentation (6)
18. Used in dentistry when an artificial denture has to be made (5)
20. Manner of walking (4)
21. An indirect method of estimating the rate of metabolism in the body, initials (3)
23. A flattened circular structure (4)
25. See 13 Across (11)
26. The coarse part of flax used for padding splints (3)
27. Chemical symbol, beryllium (2)
28. Pertaining to the organs (7)
30. An ulceration of the mouth, a rare complication of measles in debilitated children (4)
31. Composed of lymphoid tissue covered by mucous membrane (6)

DOWN

1. A feeling of exaltation (7)
2. Bleeding from the gums (10)
3. The essential constituent of all protein foods (8)
4. A hook-shaped instrument (9)
5. Relating to nervous disorder (11)
6. Occurs when there are rapidly recurring extra systoles, initials (2)
8. Latin for half; abbrev (2)
9. The simplest form into which matter can be divided (7)
11. This rate is very much increased in severe infection (3)
12. Loss of sensation in the whole of the body, induced by drugs, initials (2)
15. Instruments used in orthopedic surgery; initials (2)
19. The essential part of a cell (7)
20. A nitrogenous constituent of wheat and other grains (6)
21. Non-malignant (6)
22. Relating to the back or posterior (6)
23. There are twenty of these in the human body (5)
24. Prefix denoting under (3)
28. Occipital artery (2)
29. A colourless gas produced by incomplete combustion of coal. Chemical symbol (2)

Solution on p 13. GOW PUBLISHING © 1992

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7

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Practical aspects of hepatitis B screening in pregnancy / 62 • CLIA: confusion and frustration reign / 50 • Texas medical school enrollment increases / 28

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TexasMedicine

DECEMBER 1992 • VOLUME 88 NO. 12

Cover illustration and hand-lettering by Matt Lynaugh.

Texas Medicine Feature

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"A lot of guys out there are hurting real bad. They shouldn't have to wait for treatment."

— A Texas physician

Out of harm's way: Real help for addicted physicians

The stigma, ignorance, and fear surrounding alcoholism and drug addiction can bar physicians from the career-saving and life-saving help they need.

BY KATHRYN TROMBATORE

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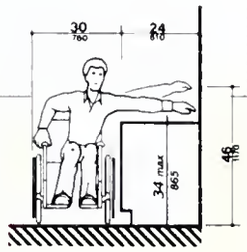

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COMPLIANCE UNDER ADA

• • •

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References:

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Letters

Open forum is vital to medicine's unity

THE OCTOBER 1992 ISSUE of *Texas Medicine* (pp 8–9) contained a letter from a member who objected to the TMA House of Delegates "getting involved in the political debate about gun control and abortion." The physician wrote: "At a time when our very existence as private physicians is being threatened by outside forces from all directions, it is crucial for us to be unified. I can think of no two issues that have more potential to divide us than gun control and abortion." He added: "I want my medical association to address and, hopefully, to solve the problems for me and my patients with regard to the practice of quality medicine." Finally, he admonishes the House of Delegates to "Please stop this unnecessary polarization of our members."

In response, I wish to remind him that the House of Delegates is the legislative and policymaking body of the association. Membership of the House includes delegates representing their county medical societies and certain voting ex officio members. The business of the House consists of reports of TMA boards, councils, committees, and sections, and resolutions offered by county medical societies or individual delegates.

In May, the House considered 121 business items, of which 51 were resolutions. The abortion and gun control matters were but two of the total number of items considered. Both were resolutions submitted by county medical societies.

Thus, a large number of components and individuals are free to bring to the House recommendations on any topic, whether strictly medical, medically related, or even nonmedical.

Some criticize medicine's organizations and processes as "too democratic" and thus inefficient. Perhaps so, but most believe that the openness of the process is one of medicine's greatest strengths and that the House serves the vital role of hearing physicians' concerns, ideas, and proposals in an open forum of debate and decision-making. The very existence of a body comprising different specialists, and urban and rural members, confirms that unity of the medical profession is a fundamental purpose of the association.

Arguably, abortion and gun control are issues that should be considered, along with all other issues that relate to patient care, public health, and professionalism. The fact that they may be controversial should not disqualify them for discussion. Their inclusion on the agenda does not mean that matters concerning the practice of quality medicine are being ignored.

Mark J. Kubala, MD
Speaker, TMA House of Delegates

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Workers' Comp: more confusion over dispute resolution

SOME OF THE COMMENTS made by the Texas Workers' Compensation Commission in the article in the September *Texas Medicine* (pp 20–22) are totally erroneous. [The article was about problems physicians are experiencing with reimbursement and utilization review by TWCC.] I think my longest unresolved case dates back to September 1989, and periodically the file is "unable to be located" until we jog their memories once more. TWCC officials are fully aware of the length of this particular case, and we have been advised to check with them every 6 months to determine its status.

In response to the comment, "Findings by the TWCC are binding," this is just not so. I am enclosing a case that went through the TWCC dispute resolution process. Although it was found in my favor, their recommendations section clearly states: "The foregoing findings and recommendation are not binding by either party."

If you are confused by the information you received from TWCC, you can imagine how our office staff feels when confronted with five or ten different interpretations of a TWCC rule or regulation, depending upon whom they speak to on a particular day.

TWCC's bureaucracy has definitely not benefitted either the injured worker or the medical care givers. Rather, it has benefitted TWCC by the creation of numerous nonfunctional jobs.

The deluge of required paper-

work is killing us. We literally are finding that taking care of patients interferes with the completion of the paperwork!

Thanks for the opportunity to vent my frustrations. TWCC speaks out of both sides of its mouth.

Don E. Johnson, MD
4207 James Casey St, #109
Austin, TX 78745

Editor's note: Dr Johnson's frustration and confusion in dealing with TWCC regulations is shared by the TMA staff and many of his colleagues. He notes correctly that for the case he submitted to TWCC's Dispute Resolution Process, the findings are *not* binding. To clarify his point, TWCC regulations say the date of injury in a case determines which set of regulations — "old law" or "new law" — will apply. The case Dr Johnson cites has a date of injury *prior* to January 1, 1991, and falls under the "old law" in place at that time, in which TWCC Rule 42.305–307 applies: Findings of the arbitration process are not binding to either party. In cases with injuries that occur after January 1, 1991 (a "new law" case), TWCC Rule 133.305 states that findings by the Dispute Resolution Process *are* binding to all parties, but either party may file an appeal to the TWCC Division of Hearings within 20 days of the finding.

It's what they don't print that counts

"A DOSE OF INFORMATION: What are your patients reading?" in the September 1992 issue of *Texas Medicine* (pp 36–42) was very well written, but it left out an important topic: journalistic censorship. Newspapers, magazines, and (to a lesser extent) the electronic media practice widespread censorship about tobacco-related diseases.

Several studies have demonstrated the correlation between reporting on tobacco-related diseases and tobacco advertising revenue in women's magazines and the national news weeklies (1–3). There is an inverse relationship with a decrease in coverage with increasing tobacco advertising income.

Although the use of tobacco will cause 434,000 deaths in the United States this year, the majority of women do not know that lung cancer — not breast cancer, which it surpassed 5 years ago — is the number one cancer killer in women. Try to find a good article about tobacco-caused diseases in a magazine for women or minorities. If the article is good, the publication probably does not accept tobacco advertising; if cigarettes are not mentioned or are mentioned only on the last page of the article, chances are good the publication accepts tobacco ads.

Newspapers typically advocate balanced reporting, but this means that for any article critical of tobacco, the editors feel obliged to get comments from the Tobacco Institute or the tobacco industry. And unlike the health advocate, the institute or industry usually is not required to provide references to support its rebuttal.

Newsweek has censored an AMA health supplement (4) and *Time* censored an American Academy of Family Physicians health supplement (5) by removing almost all references to the health effects of cigarettes.

The *Houston Post* and *Houston Chronicle* accept tobacco ads, but have refused paid counter ads from Doctors Ought to Care (DOC). Additionally, the *Houston Post* published a three-part article on Texas lobbyists that included a section on TMA's lobbyists, but omitted mention of the 17 lobbyists registered to tobacco companies who have killed all important pro-health tobacco legislation in the last five legislative sessions. And neither paper mentioned the influence of the tobacco industry on the Bush campaign or the Republican National Convention.

Until we finally see the week-long segment on our local television channels or in our local papers about lung cancer and women, the most important aspect of medical reporting in the lay press is what they don't print.

Joel S. Dunnington, MD
Department of Diagnostic Radiology
The University of Texas M.D. Anderson Cancer Center
1515 Holcombe Blvd
Houston, TX 77030

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4. Personal health care: A guide to health, physical fitness and nutrition. *Newsweek*. November 7, 1983.
5. Lifestyle/Healthstyle: Strategies for a healthier, happier, and longer life. *Time*. October 8, 1984.

Managed care threatens doctor/patient relationship

WITH REFERENCE TO THE article on managed health care in the October issue of *Texas Medicine* (pp 36–44), Texas physicians are not so naive that their main objection to managed health care is "feeling that they have lost control." Long before managed health care, physicians accepted practice controls in accordance with standards of care, hospitalization bylaws, quality assurance, and peer review.

What Texas physicians predominantly object to is managed care's heinous destruction of the traditional doctor/patient relationship, which is fundamental to primary care medicine. Decisions about how frequently to refer patients, when to call in consultants, how much technology to use, and when and where to hospitalize patients depend on comprehensive, intimate knowledge of patients and their families. That knowledge is obtainable only by adequate continuity of primary care.

PPOs and IPAs ring up annual changes in providers, encourage cronyism between managed care providers ("jobs for pals") (1), and eliminate incentives to do one's very best since salaried HMO positions are not contingent upon patient free choice. These are the more obvious evils of managed health care, which is progressively eroding quality care. The inevitable duplication of services, overutilization of technology, and emphasis on volume over quality of service complete the picture of depersonalized medical care under the managed health care philosophy.

Theodore Pearlman, MD
7505 S Main, #320, Houston, TX 77030

1. Pearlman T. *The Threatened Medical Identity of Psychiatry: The Winds of Change.* Springfield, Ill: Charles Thomas; 1992.

Why aren't there more physician 'extenders'?

AT A RECENT MEETING OF the Texas Pediatric Society and the Texas Chapter of the American Academy of Pediatrics, spirited debate accompanied the question of using allied health personnel, such as nurse practitioners, physician assistants, and other physician extenders, to serve the flood of children newly eligible for private care through Medicaid.

Since 1969, I have increased the number of patient visits I can schedule by using a certified pediatric nurse practitioner. Together, we handle the red tape, see approximately 40 patients a day (about 90% are Medicaid patients), and make a comfortable living.

Question: Why should not more pediatricians practice as we do?

Answer: There are not enough trained nurse practitioners and physicians assistants.

I am familiar with the problem. I may have been the first Texas practitioner to identify my office helper as a physician extender. This was in 1969, when the only training facility was at Duke University, and its graduates were all employed.

Subsequently, I chaired the Manpower Committee of the Texas Pediatric Society and promoted the training and utilization of physician extenders. Many of the state's medical schools began training programs in the 1970s. We particularly hoped the assistants would help rural physicians who were abandoning small communities due to unbearable work loads.

Since 1970 the number of trained physician extenders has gradually diminished and few are being trained. This is the result of a number of factors:

1. Physicians are reluctant to delegate responsibility for a patient's well-being to someone less well trained.
2. The public is wary of medical practitioners who are not "doctors."
3. Medical schools have phased out such training in the face of budget demands.
4. Established physicians fear extenders will set up competitive practices.

But the chief reason for the failure of the program is economic. Prior to Medicaid reimbursement, physicians (particularly those in rural practice) were unable to compensate extenders adequately because they usually cared for indigent patients with no compensation.

Physician extenders with families could not live in small communities on the salaries physicians could afford to pay. Consequently, many moved to the HMOs or large proprietary clinics in cities. Thus private pediatricians in cities found themselves competing against clinic groups that were using the very persons we had hoped would be of help to private practice.

Today, the situation is turned about. With enhanced Medicaid reimbursement we now have sufficient compensation for physician extenders in rural communities or private practice, but few extenders are available.

Is this a Catch 22?

Ralph Chase, MD
West Texas Medical Associates
3555 Knickerbocker Rd
San Angelo, TX 76904

Near fatality results from health food store sleeping potion

MEDICATIONS PURCHASED over-the-counter from health food stores are presumed to be innocuous, pure, and safe. Some consumers prefer these resources believing that their production is not influenced by the profit motive governing the "medical health-care industry."

The universal phenomenon of insomnia has generated many attempts to find nonprescription remedies. The inexpensive synthesis of L-tryptophan and its former availability in health food stores led many individuals to try this ostensibly innocuous amino acid as an effective sleep medication. L-tryptophan is a mildly soporific agent found in milk. Unappreciated toxicity was noted with commercial L-tryptophan products, and its safety was ultimately discredited after approximately 10,000 cases of eosinophilia-myalgia syndrome, including 31 deaths, were identified (1).

Another preparation quickly appeared to meet the market demand. Commonly known as GHB, the crystalline material is chemically known as gamma hydroxybutyrate but also referred to as gamma hydrate, somatomax, and sodium oxybate. Unfortunately, it is associated with a number of serious neurologic, cardiovascular, respiratory, and gastrointestinal side effects. In addition to its sedative and euphoriant qualities, it was sold illicitly to body builders as a steroid alternative.

Case presentation — A 24-year-old healthy student was admitted to a Dallas hospital in a state of pulmonary arrest. Several hours earlier, after consuming several beers, he had taken a small amount of GHB, purchased for the purpose of getting "high." Subsequently, the patient and his companions headed for their social destination. Upon reaching an appointed rendezvous, he felt nauseated, lurched from his stopped car, vomited, and collapsed in a state of obvious distress.

He was found by the emergency medical service and given Narcan without improvement in his sensorium. Shortly after entry into the emergency room he suffered respiratory arrest and required intubation and a ventilator. The patient's sensorium improved over the ensuing few hours, but he was maintained on the ventilator overnight and received inhalational bronchodilator therapy because of diffuse bronchospasm.

The following morning his arterial blood gases, chest x-ray, and physical examination had improved sufficiently to allow extubation.

He was discharged in stable condition 24 hours later and close follow-up yielded normal mental status and physical condition.

The removal of home remedies from health food stores is difficult to accomplish due to erratic enforcement policies.

This case of near death is a convincing example of the need for more thorough regulation of a very dangerous medication.

Burton C. Einspruch, MD
Pecan Creek, Suite 117
8330 Meadow Rd
Dallas, TX 75231

S. Michael Clark, MD
8230 Walnut Hill Lane, #804
Dallas, TX 75231

1. Abelson K. Killer acids. *Forbes*. September 2, 1991.

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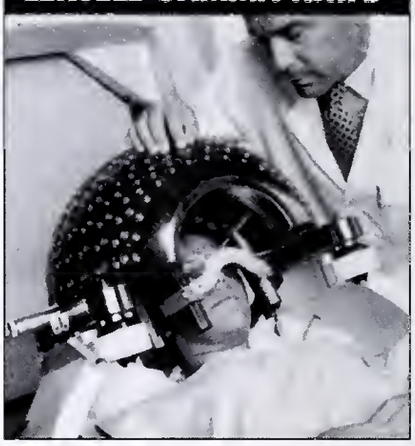

The Gamma Knife significantly lowers the common risks of craniotomy by replacing the scalpel with 200 beams of gamma rays that can treat brain tumors and vascular anomalies in a single treatment. In many cases the Gamma Knife can be used to treat conditions that are otherwise inoperable. It does not require general anesthesia. It significantly impacts mortality and morbidity; patients can often return to work the next day. It requires no blood transfusions and involves no danger of wound infections.

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Upfront

Physicians, attorneys join in drug, alcohol abuse prevention project

PHYSICIANS AND ATTORNEYS across the state are joining forces to fight growing alcohol and drug problems among young people by educating them about the legal and medical consequences of substance abuse.

As part of a joint American Bar Association-American Medical Association project, teams of physicians and attorneys will speak to sixth-grade classes around the state about substance abuse. The Drug and Alcohol Abuse Prevention Project is cosponsored by the Texas Young Lawyers Association (TYLA) and the Young Physician Section of TMA.

Charlotte Smith, MD, an Austin physiatrist, is coordinating the project for TMA.

"It is important for young children to understand the problems connected with substance abuse and the effect it can have on their lives," she said. "We encourage physicians to join in the program to help provide a positive role model for these children. We think it is a worthwhile effort."

Lowell Keig, JD, of San Antonio, is the project chairman for TYLA.

"Lawyers and doctors are both good role models for young children," said Mr Keig. "The pairing of the two will give the kids a perspective on both the legal and medical consequences drug and alcohol abuse can have."

Mr Keig said that although the Young Lawyers and Young Physician groups are sponsoring the project, attorneys and physicians of all ages are encouraged to volunteer for the program.

The program will provide teaching materials to volunteers, who will be asked to teach a 1-hour class and answer questions from sixth graders, he said.

To volunteer, or for more information, contact Mr Keig at (210) 227-7565, his wife, Elizabeth Keig, JD, at (210) 554-5303, or Corinne Hebda, TMA staff liaison to the TMA Young Physician Section at (800) 880-1300 or (512) 370-1441.

TMA Annual Session set in Houston May 13–16

IT'S NOT TOO EARLY to make plans to attend Texas Medical Association's 126th Annual Session, to be held May 13–16, 1993, at the George R. Brown Convention Center in Houston.

The theme of the conference is "Improving the quality of life through disease prevention and health promotion." More than 40 scientific programs across the medical spectrum will be presented with a focus on primary care. In addition, general sessions examining the topics of medical ethics and family violence are planned. Other programs are planned on physician-patient communication, and a symposium on pain control will feature an international group of speakers. Several social events are planned in conjunction with the conference.

Conference planners expect more than 5,000 Texas physicians to attend the meeting in Houston, site of the Texas Medical Center, one of the world's largest medical complexes. Houston, the nation's fourth largest city, has a variety of attractions, including NASA, the Astrodome, Space City Museum, a world-class museum district, as well as nationally known shopping centers, theaters, and restaurants.

A special information section on TMA's 126th Annual Session, including registration materials and a listing of symposia, will be published in the January and March editions of *Texas Medicine*. For more information, contact the TMA Annual Session planning office at (800) 880-1300 or (512) 370-1451.

Public health, communication gain emphasis at TMA

IN LINE WITH THE ASSOCIATION'S emphasis on improving the health of all Texans and strengthening member communication, two new staff divisions have been created at Texas Medical Association.

The Division of Public Health and Scientific Affairs, formerly a department, provides staff support in the areas of public health and scientific affairs, including the Physician Oncology Education Program. Catherine Edwards, PhD, who directed the public health department, heads the division.

The Division of Communication is responsible for primary TMA communications to the membership and public, including *Texas Medicine* and *Action*, and public relations activities, graphics, and advertising. Kathryn Trombatore, managing editor of *Texas Medicine*, heads the division.

Other divisions at TMA are:

- Administrative Services, which administers the financial and op-

erations aspects of the association;

- General Counsel, which includes the departments of corporate law, health law, and medical ethics;
- Medical Information, which comprises the departments of annual session and meeting management, the library, and medical education;
- Medical Economics, which includes the departments of health-care delivery, health-care financing, practice management services, and quality assurance/utilization review; and
- Public Affairs, which contains the legislative affairs and political education departments.

Physicians Benevolent Fund eases financial burden

EACH MONTH, 21 TEXAS Medical Association families are finding financial protection under the umbrella of the Physicians Benevolent Fund (PBF).

The PBF, which is managed and maintained by TMA and TMA Alliance (TMAA), has provided more than $2 million over the past 30 years to destitute physicians and their families. The program remains alive today because of the generosity of physicians willing to share financially with less fortunate colleagues and families.

"It would do so much good if all doctors and their families in Texas would just give $10 a year to the PBF," says Charles A. Rush, Jr, MD, former cochairman and member of the Joint Committee on PBF of TMA and TMAA.

In 1991, the annual October fundraising campaign reached a record high in contributions of $71,104. PBF program administrators are hoping to raise $80,000 during this year's fundraiser. Contributions are accepted throughout the year.

Monthly assistance payments total $14,500 with an average of less than $700 a month being paid to each family. Physicians or their families who currently receive funds each month are either elderly and not practicing; disabled or suffering from ill health; or widowed and raising families with no other means of support.

Established in 1961 with a $2,500 donation from the late May Owen, MD, a Fort Worth pathologist and past president of TMA, the nonprofit, tax-exempt fund began distributing funds in 1965 to assist physicians with rent, mortgage, utilities, insurance, medical bills, clothing, and food.

In the last 5 years, assistance payments have continued to increase while contributions to the fund have remained relatively the same. By 1990, assistance payments reached a high of $203,912 and exceeded con-

Celebrating Our Diamond Jubilee 1918-1993

NEW BOOK CELEBRATES TMAA HISTORY

"CELEBRATING OUR DIAMOND JUBILEE — 1918–1993" is the title of the 75-year history of the Texas Medical Association Alliance written by Helen Alexander, of Houston, assisted by Elizabeth Nixon, also of Houston. The book chronicles the alliance from pre-organization days as "The Visiting Ladies" through the years as an auxiliary and its emergence as a strong force for organized medicine in community service, politics, and legislative action. The book also incorporates data compiled by Frances Hatfield, El Paso, who wrote the organization's 50-year history.

Helen Alexander has been chairman of the Medical Heritage Committee of TMAA for several years. The wife of former TMA President George Alexander, MD, she has served as president of both the Southeast Harris County and Harris County auxiliaries. She founded the Pasadena Historical Society and the Pasadena Museum and serves on the State Advisory Board of the Texas San Jacinto Museum of History and on the TMA History of Medicine Committee.

Elizabeth Nixon, wife of former TMA President Sam Nixon, MD, has served as president of the Gonzales Medical Society Auxiliary and as council woman for the district. She has been on the Medical Heritage Committee of TMAA for several years.

Frances Hatfield, president of the state auxiliary in 1959–1960, was author of the Fiftieth Anniversary History of the Woman's Auxiliary to the Texas Medical Association, published for the 50th anniversary convention held in Houston in 1968.

The book contains more than 250 photos, including those of all 75 past state presidents, political events, health fairs, convention delegations, and many other subjects.

The history is available in paperback for $15, with a limited number of hardback volumes available for $40. Suggested for Christmas gifts, doctors' offices, libraries, and thank-you gifts to medical friends, it is available from TMAA, 401 W 15th St, Austin, TX 78701; telephone (800) 880-1300, ext 1328/1329/1331.

tributions, thus depleting the fund balance by $71,817. In response, modifications to the fund's existing policies were made in 1991 to adjust to the dwindling funds. Changes include reducing the monthly maximum assistance available to each recipient to no more than $1,000 and conducting a more aggressive fundraising campaign. As a result, the fund's balance was increased from $788,500 in 1990 to $817,066 in December 1991.

Overseeing the program is the Joint Committee on Physicians Benevolent Fund of TMA and TMAA. The committee is composed of nine physicians and eight TMAA members. Physicians are appointed for 10-year terms by the TMA president, and TMAA members hold 3-year seats. Robert Colpitts, MD, Houston, is chairman and Martha Antoni, Corpus Christi, is cochair. The committee meets in September and May to consider applications for assistance. Emergency applications are reviewed by the chairman and cochair of the committee. The status of recipients is reviewed every 6 months to determine if needs are being met and if assistance is still needed.

The continuation of the PBF is made possible through donations, which are tax-deductible and may also be in the form of honoraries or memorials. Contributions should be sent to Physicians Benevolent Fund, Texas Medical Association, 401 W 15th St, Austin, TX 78701. For additional information on the fund, contact Suzanne Aldrich, (800) 880-1300, ext 1470. ★

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CASE HISTORY

From the Files of ICA

CASE SUMMARY

A divorced mother of three children presented in the office of a family practitioner with her three-year-old son. He was irritable and had a fever of 103° rectally. An examination revealed a red eardrum without apparent pus or fluid in the middle ear. The child was placed on amoxicillin and given an appointment for three days later.

The appointment was not kept. The office nurse called the mother, leaving a message on the answering machine to call the doctor's office.

Three weeks later, the doctor received a letter from the mother stating that her child could not keep the medicine down and became worse. She saw a pediatrician who said "that her doctor should have prescribed something for nausea with her other prescription." He found the eardrum to be perforated and remarked, "This could have been avoided." She was referred to an otolaryngologist, and ultimately her medical bills were over $500. She enclosed her medical bills and demanded payment or she would "get a lawyer."

1. What was the event(s) or factor(s) precipitating the unfortunate chain of events, and how might this situation been avoided early on?
2. What arguments could have been made in this doctor's defense?
3. What was the role of the second doctor in this sequence of events? What should his role have been? How would you have changed his behavior?
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People

NEWSMAKERS

San Antonio obstetrician and gynecologist **M. Derick Boldt, MD,** was appointed vice chairman of the committee on physician executives of the Texas Hospital Association.

Garnett Bryan, MD, Amarillo, was chosen Family Physician of the Year by the Panhandle chapter of the Texas Academy of Family Physicians.

Brian Bull, MD, Waco, received the Society of Teachers of Family Medicine award during the Waco Family Practice Residency Training Program graduation ceremonies.

The US Department of Health and Human Services' Division of Research Grants has named **Bruce R. Carr, MD,** to serve as chair of the reproductive endocrinology study section. Dr Carr is a professor of obstetrics and gynecology at The University of Texas Southwestern Medical Center at Dallas.

G. Patrick Clagett, MD, professor of surgery and head of vascular surgery at The University of Texas Southwestern Medical Center at Dallas, was appointed to the editorial board of *Stroke*, the American Heart Association journal.

The 1992 Texas Academy of Family Physicians officers are **Kenneth Davis, MD,** Conroe, president; **Jim Randles, MD,** Waco, president-elect; **Lewis Foxhall, MD,** immediate past president; **Thomas Mueller, MD,** La Grange, vice president; **Sheri Talley, MD,** Fort Stockton, treasurer; and **William Featherston, MD,** Dallas, parliamentarian.

Robert A. Dobie, MD, professor and chairman of otolaryngology-head and neck surgery at The University of Texas Health Science Center at San Antonio, will serve as an advisor to the board of directors of the Deafness Research Foundation, which is headquartered in New York.

The "Ralph D. Feigin Visiting Student Scholarship Fund" was established by the medical staff at Texas Children's Hospital in Houston to honor physician-in-chief, **Ralph D. Feigin, MD.** In addition, a scientific display area recognizing Dr Feigin's service to the hospital is being built.

Francisco Fernandez, MD, associate professor of psychiatry and behavioral sciences at Baylor College of Medicine, was appointed to the American Psychiatric Association's Commission on AIDS through 1995.

Houston neurologist **William H. Fleming, III, MD,** was elected president of the Texas State Board of Medical Examiners.

Ted H. Forsythe, MD, Lubbock obstetrician/gynecologist, was honored with the establishment of a distinguished professorship in women's health care at Texas Tech University Health Sciences Center in Lubbock. Dr Forsythe is vice chairman of the Texas Delegation to the American Medical Association.

Rafael Garza, MD, McAllen, received the Texas Academy of Family Physicians Oncology Award for 1992.

Rebecca Gruchalla, MD, instructor of allergy at The University of Texas Southwestern Medical Center at Dallas, received the Boehringer Ingelheim joint award from the American Academy of Allergy and Immunology and the National Institute of Allergy and Infectious Disease. She also has been named the 1992 recipient of the Allen & Hanbury's Basic Research Award in Allergy and Immunology.

L. Leighton Hill, MD, Houston, received the 1992 Sidney Kaliski Award from the Texas Pediatric Society. Dr Hill was honored for outstanding service to the society and for promoting the health and welfare of Texas children.

Neurologist **Joseph Jankovic, MD,** director of the Parkinson's Disease Center and Movement Disorder Clinic at Baylor College of Medicine, was chosen president-elect of the international Movement Disorder Society.

Gastroenterologist **Kermit B. Knudsen, MD,** president at Scott and White Clinic and chief of staff at Scott and White Memorial Hospital, was given the Russell V. Lee Lectureship Award by the American Group Practice Association.

Leonard Lawrence, MD

Psychiatrist **Leonard Lawrence, MD,** associate dean for student affairs at The University of Texas Health Science Center at San Antonio, is the

Please let *Texas Medicine* know about your honors and achievements.

Criteria for inclusion in the Newsmakers section are: TMA member; election or appointment to an office of, or honors from, a national or state organization; or, space permitting, recognition at the local level. Items for the Newsmakers section are published at the discretion of the managing editor. Submit items for consideration, with photos if possible, to People, Texas Medicine, *401 W 15th St, Austin, TX 78701.*

president-elect of the National Medical Association.

Family practitioner **James C. Martin, MD,** has been named 1992 Medical School Distinguished Alumnus of The University of Texas Health Science Center at San Antonio.

Haden E. McKay, MD

Haden E. McKay, MD, general medicine specialist and mayor of Humble, will receive the 1992 Dr Nathan Davis Award from the American Medical Association in the category of Mayor of a City, during a recognition dinner in Washington, DC, on February 2, 1993. This award is presented for outstanding contributions "to promote the art and science of medicine and the betterment of public health" and is awarded to elected and career public servants in national, state, and local governments. In addition to his medical and municipal duties, Dr McKay has been vice president of the Harris County Medical Society, a delegate from Texas to the AMA House of Delegates, a past president of the Texas Academy of Family Physicians, and a past chairman of the TMA Board of Councilors. He received the TMA Distinguished Service Award in 1979 for his contributions to medicine and the state. Dr McKay is the first physician-mayor to be honored in the four years the award has been presented.

William L. Meyerhoff, MD, chairman of otorhinolaryngology at The University of Texas Southwestern Medical Center at Dallas, received the American Academy of Otolaryngology-Head and Neck Surgery's Honor Award.

James Mobley, MD, Portland, received the Order of Military Medical Merit after his 5-year tour as commander of a US Army reserve hospital in New Orleans. Dr Mobley was ranked in the top 10% of family practitioners in the Medical Corps.

Robert D. Moreton, MD, vice president emeritus at The University of Texas M.D. Anderson Cancer Center, was recognized with the 1992 Gold Medal of the American College of Radiology. This award, the organization's highest honor, is given for distinguished and extraordinary service.

Robert E. Myers, MD

Scott and White Memorial Hospital President **Robert E. Myers, MD,** was named president and **Clinton E. Craven, MD,** Austin, was named president-elect of the Texas Pediatric Society.

Beaumont rancher and family practitioner **Charles R. Sherron, MD,** has been appointed to the Texas Animal Health Commission for a 6-year term. **Bobby L. Shull, MD,** Temple, was elected vice chairman of the Texas section of The American College of Obstetricians and Gynecologists.

The Texas Ophthalmological Association received the 1992 Model State Society Award from the American Academy of Ophthalmology. The TOA also received this award in 1991. The current president is **David Shulman, MD,** San Antonio, and the immediate past president is **John Dugan, MD,** Corpus Christi.

San Antonio psychiatrist **Lawrence A. Stone, MD,** is the newly appointed representative to the Advisory Committee for the Long Term Care Program of the Joint Commission on Accreditation of Health Care Organizations.

Russell Thomas, Jr, DO, Eagle Pass, was nominated to the Texas Trauma Technology Advisory Committee to represent family physicians and rural health delivery.

Steven E. Wilson, MD, assistant professor of ophthalmology at The University of Texas Southwestern Medical Center at Dallas, received the William and Mary Greve International Research Scholar Award from Research to Prevent Blindness.

OBITUARIES

Jack A. Bergfield, MD, 75; New Braunfels; Tulane University, 1943; died September 28, 1993.

Thomas J. Fatheree, MD, 85; Houston; Tulane University, 1932; died October 2, 1992.

Ronnie Lee Jackson, MD, 32; Brownfield; The University of Texas Southwestern Medical Center at Dallas, 1987; died September 10, 1992.

Antone C. Fina, MD, 71; Plano; Northwestern University Medical School, 1947; died September 25, 1992.

Charles William Hall, MD, 70; San Antonio; Kansas University School of Medicine, 1956; died September 18, 1992.

Fred F. Johnston, MD, 59; Dallas; University of Pennsylvania School of Medicine, 1958; died September 4, 1992.

Teresa Elizabeth McCain, MD, 27; Houston; The University of Texas Health Science Center Medical School at Houston, 1991; died September 14, 1992.

Samuel E. Neely, MD, 67; Dallas; University of Oklahoma Medical School, 1948; died October 5, 1992.

Raul F. Perez, Jr, MD, 61; San Antonio; National University of Mexico, 1959; died September 15, 1992.

Robert D. Rice, MD, 69; Tyler; The University of Texas Medical Branch at Galveston, 1954; died September 2, 1992.

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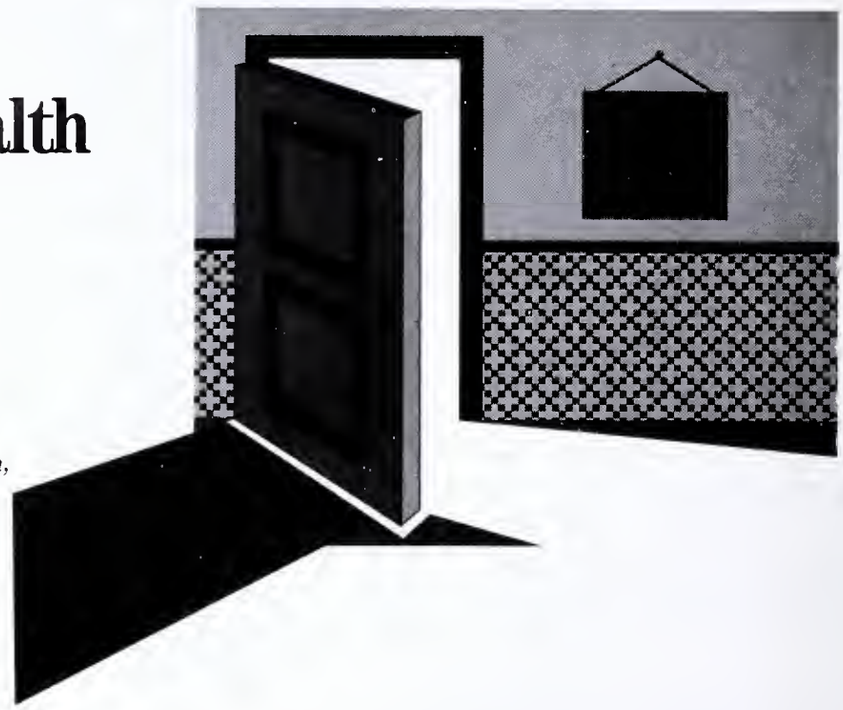

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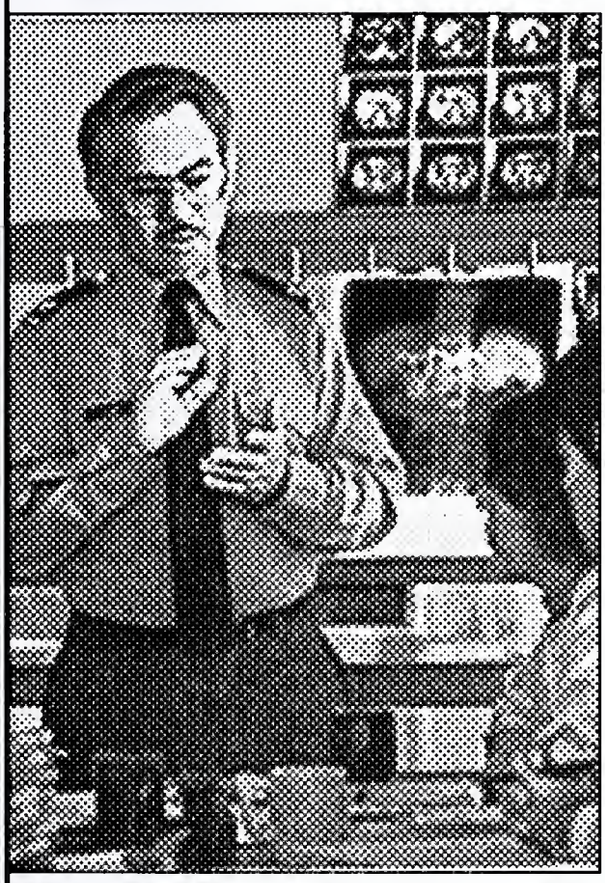

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Legislative Affairs

Task force proposes nurse prescribing, sends report to governor

THE TEXAS HEALTH POLICY Task Force's sweeping recommendations for health-care reform are on their way to Gov Ann Richards, after only a handful of minor changes were added at the panel's meeting in September.

Texas Medical Association President William G. Gamel, MD, has characterized the panel's report as "95% good," saying many segments of the report reflect measures TMA and other health-care organizations have been advocating for some time. However, one last-minute addition calling for broader scope of practice for midlevel practitioners will be opposed strongly by TMA.

When the task force met September 29 and 30 to adopt its final report, panel member Sue Iha, a registered nurse, offered beefed-up language calling for removal of barriers to allow advanced nurse practitioners and physician assistants to prescribe, have clinical privileges, and receive third-party reimbursement. The new language, which was included in the report without a vote of the task force, states:

> Greater utilization of advanced nurse practitioners (ANPs) and physician assistants (PAs) would improve access to preventive and primary care, but barriers currently exist that prevent such utilization. Accordingly, the Task Force recommends removal of these barriers in order to allow ANPs and PAs to participate to the full extent of their education and skills including the barriers of lack of prescriptive authority, clinical privileges and third-party reimbursement.

While nurse practitioners argue the expanded scope they seek would be a cost-effective way to improve access to care in underserved areas, they also have argued for equal pay with doctors. There are no studies indicating that these mid-level practitioners would be any more willing than physicians to go to underserved areas where there are fewer paying patients, Dr Gamel says. In fact, statistics show there are more physicians than mid-level practitioners in underserved areas now.

TMA has suggested that barriers that unnecessarily limit the role of midlevel practitioners can be modified as long as those providers practice in a team setting linked to physician supervision.

While TMA opposes the recommendations on advanced nurse practitioners and physician assistants, the association does support many of the task force's recommendations, some of which are based largely on recommendations of TMA's own Ad Hoc Committee on Financing and Availability of Health Insurance.

Among key recommendations included in the task force report are creation of a Texas Children's Health Plan (TCHP) to ensure access to health care for all children and pregnant women, expansion of Medicaid eligibility, enactment of private insurance reforms, development of incentives to encourage health-care providers to accept Medicare and Medicaid, full funding of a statewide trauma system, and enactment of cost-containment measures.

> WHILE TMA OPPOSES THE RECOMMENDATIONS ON ADVANCED NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS, THE ASSOCIATION DOES SUPPORT MANY OF THE TASK FORCE'S RECOMMENDATIONS.

The recommendation on nurse practitioners and physician assistants was among only a handful of changes made in the task force report at the September meeting. Among other changes was inclusion of language recognizing that physician fees paid by the proposed TCHP must be higher than current Medicaid fees if the program is to be viable. Another change called for an economic analysis of a single-payor system.

Cost estimates for the TCHP, which put the program's price tag for 1994 at $4.2 billion, were based on projected 1994 Medicaid payments. "Actual payment rates in the TCHP will be negotiated, and actual costs may differ from current Medicaid costs when prevailing private rates, cost savings in administration, reduced paperwork, and elimination of uncompensated care and cost shifting for children and pregnant women are taken into account," the newly adopted provision states.

The call for the Texas Department of Health and State Comptroller's Office to perform an economic analysis of a single-payor system replaces an earlier recommendation that the state move toward a single-payor system.

Ken Ortolon, *legislative affairs editor, writes and edits the Legislative Affairs section of* Texas Medicine.

OSHA review, student loans among congressional victories

A REVIEW OF HOW A NEW bloodborne pathogens standard affects physician offices and improvements in student loan deferments are among organized medicine's major legislative victories during the 102nd Congress, which adjourned in early October.

However, the most important potential victory — major improvement in Medicare physician payments — fell victim to a veto by President George Bush.

The Occupational Safety and Health Administration (OSHA) was instructed to reexamine how its bloodborne pathogens standard affects physician offices under a provision included in the Department of Labor/Department of Health and Human Services appropriations bill. That provision also requires OSHA to consult with physician organizations during the review.

The standard was implemented this year in an effort to protect workers in physician offices, dentist offices, hospitals, clinics, and other health-care facilities from being exposed to the human immunodeficiency virus or hepatitis B virus. The standard places a heavy burden on physician offices in terms of expenditures for personal protective equipment, staff training, housekeeping services, employee vaccinations for hepatitis B, recordkeeping, waste disposal, and more. Federal estimates place the cost of compliance with the standard at roughly $800 million.

In the reauthorization of the Higher Education Act, Congress did an about-face on a proposal to eliminate student loan repayment deferments. Instead it voted to expand eligibility criteria for such deferments.

MAJOR IMPROVEMENTS IN MEDICARE THAT WERE AMONG TEXAS MEDICAL ASSOCIATION PRIORITIES FOR 1992 WERE VETOED BY PRESIDENT BUSH.

Loan forbearance options also were enhanced, and the reauthorization allows accreditation programs for medical schools and allied health professions to continue under existing arrangements.

Other measures passed by Congress include legislation to establish the American Medical Association's National Credentialing Verification Services as a repository of medical credentials for international medical graduates and legislation to establish new criminal penalties for violence against medical research laboratories and other facilities using animals. A measure to mandate that physicians complete continuing medical education on infection control for purposes of state relicensure was defeated.

Mr Bush vetoed the Medicare legislation because it was part of a larger urban aid bill that included $27 billion in new taxes. The president had threatened to veto the bill during the closing weeks of the campaign, but congressional leaders hoped they could avoid that veto by using a parliamentary ploy to delay sending the measure to Mr Bush, thereby allowing him to sign it after election day.

The move didn't work. Mr Bush, who had pledged never to sign another bill raising taxes, signed the veto message the day after his defeat by Arkansas Gov Bill Clinton.

The major improvements in Medicare were among Texas Medical Association priorities for 1992. They would have forced the Health Care Financing Administration to use more recent and accurate data in calculating geographic practice cost indices, repealed the Medicare payment disparities for new physicians, and restored payments for electrocardiogram interpretations.

Two other bills supported by AMA were vetoed by President Bush. One would have repealed the gag rule that prohibits health professionals from discussing abortions in federally funded clinics. The other would have lifted the ban on federal funding for fetal tissue research.

Senate panel calls for sweeping psychiatric hospital reforms

PSYCHIATRIC HOSPITALS AGAIN will come under major scrutiny by Texas lawmakers in 1993, thanks to a long laundry list of reforms proposed by a special Senate committee.

More than 100 proposed reforms that may require as many as 8 to 10 separate pieces of legislation were unveiled in late September by the Senate Interim Health and Human Services Committee. The proposals are designed to curb abuses in the psychiatric hospital industry exposed following a San Antonio incident in which a teenage boy was committed to a psychiatric hospital despite his parents' objections. The reforms also would build on legislation supported by Texas Medical Association and

passed in 1991 to ban payment of fees for referral of patients.

Proposals recommended by the interim committee include:

- Reducing from 96 to 24 hours the maximum time a private psychiatric hospital may hold a patient to assess whether he or she is dangerous.
- Allowing patients the right to refuse therapy and psychotropic drugs.
- Creating a "whistleblower" provision to protect health-care professionals who report abuses.
- Providing disciplinary action and criminal penalties for therapists involved in "intimate relationships" with their patients.
- Prohibiting the use of electroconvulsive therapy on minors less than 16 years old and requiring reporting of such treatment.
- Requiring all facilities to post a patient bill of rights and ensuring that patients may make telephone calls, receive uncensored mail, and communicate with an attorney.
- Expanding patient bounty-hunter laws beyond just the medical profession.
- Mandating Texas Education Agency rules governing the relationship among school districts, treatment facilities, and outside counselors.
- Strengthening penalties for government employees involved in patient bounty-hunting.
- Allowing state agencies to levy penalties against health-care providers who bill patients for fraudulent or unnecessary treatment.

"A PHYSICIAN SPECIALIZING IN THE FIELD OF PSYCHIATRY IS THE ONLY PERSON PROPERLY EDUCATED AND TRAINED TO MAKE THESE ADMISSION DETERMINATIONS."

TMA and the Texas Society of Psychiatric Physicians (TSPP) have been monitoring the committee's deliberations closely and support most of its recommendations. However, John Bush, TSPP executive director, says his organization has serious concerns about some recommendations, particularly the proposals on electroconvulsive therapy for minors.

"While it's a rare therapy for people that age, it is given to people less than 16 years old and is effective," Mr Bush says. "We just don't want state government telling physicians what they can't do in terms of therapy."

Another concern is the lack of recommended legislation on admissions to psychiatric hospitals, Mr Bush says.

"We want the committee to strengthen their recommendations on the admissions process," he says. The committee's proposed legislation addresses patient intake and assessment procedures but does not address who can admit a patient to a psychiatric hospital. Rules adopted by the Texas Department of Health (TDH) and Texas Department of Mental Health and Mental Retardation (TXMHMR) require a physician to examine patients prior to admission and TSPP would like that requirement included in the proposed legislation.

In a letter sent to committee members in August, TMA President William G. Gamel, MD, also asked the committee to address admissions in its recommendations.

"Obviously, the decision to admit a patient to a psychiatric facility must rest with a professional properly educated and trained in the broad range of psychiatric illnesses," Dr Gamel wrote. "A physician specializing in the field of psychiatry is the only person properly educated and trained to make these admission determinations."

Mr Bush says many of the committee's recommendations already have been put into effect by TDH and TXMHMR.

"Most of these recommendations already were addressed some months ago by the state agencies, who have been very responsive and should be given credit for how they've dealt with the situation," he says. ★

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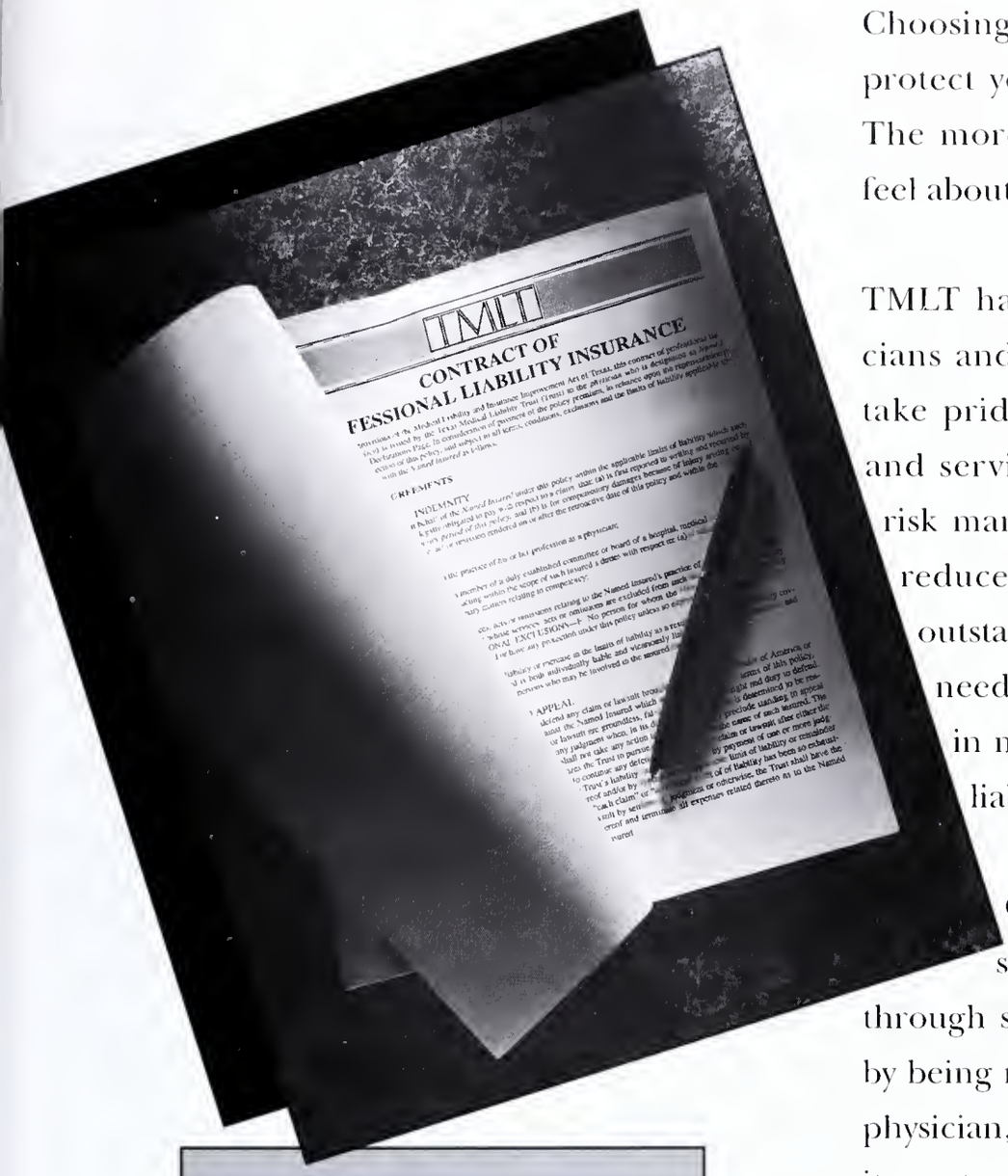

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Science and Education

Texas medical school enrollment increase is most in a decade

THE EARLY "HEAD COUNT" of students enrolled in Texas medical schools showed its largest increase in a decade this fall, more than a 2% jump from 1991 to 1992, according to figures released by the Texas Higher Education Coordinating Board in October. The increase was part of a larger trend of enrollment increases across the board in Texas public higher education institutions.

The trend concerns many education leaders who say in an era of declining funds for colleges, increased enrollment may threaten the quality of education in the state's medical and other institutions.

"Continuing significant increases in enrollment year after year are making it more and more difficult for our colleges and universities to maintain quality programs in the face of declining revenues to support them," said Kenneth H. Ashworth, PhD, Commissioner of Higher Education.

In addition, the Texas Legislature is expected to study adopting the concept of "performance-based funding" for all state institutions, which will put pressure on schools to meet predetermined performance goals in order to gain equal or increased funding in future budgets. Medical students, many already burdened with massive amounts of debts, may have to take on an ever larger responsibility for financing their education. The average medical student in Texas graduating from a public institution leaves school more than $35,000 in debt.

There were 100 more medical students enrolled in fall of 1992 than in the fall of 1991, according to board figures. Much of the increase came at the Texas College of Osteopathic Medicine in Fort Worth, which had an additional 37 students, an almost 10% increase above 1991 enrollment. Most other Texas medical schools showed a moderate (2% to 3%) increase over the previous year, and Baylor College of Medicine showed a slight decrease in enrollment.

Board officials say the "head count" numbers are preliminary, and a final enrollment count may be adjusted up or down slightly to reflect adds, drops, and transfers in the various programs. A statistical breakdown of medical students by sex, age, and ethnicity will be available later in the school year.

Medical school enrollments in Texas, 1983-1992.

Medical School	Fall 1983	Fall 1988	Fall 1989	Fall 1990	Fall 1991	Fall 1992	Change from 1991 to 1992
Texas A&M College of Medicine	149	193	191	187	186	192	3.23%
Texas College Osteopathic Medicine	387	391	378	372	379	416	9.76%
Texas Tech School of Medicine	388	397	391	387	387	396	2.33%
UT Medical School/Houston	806	786	779	768	780	794	1.79%
UT Medical School/San Antonio	802	794	800	818	815	829	1.72%
UT Medical Branch	795	755	756	768	778	806	3.60%
UT Southwestern Medical School	801	792	789	793	791	792	0.13%
Baylor College of Medicine	672	646	652	651	665	656	-1.35%
Total annual enrollment	4,800	4,754	4,736	4,744	4,781	4,881	
Change from previous year	1.27%	-0.96%	-0.38%	0.17%	0.78%	2.09%	

Source: Texas Higher Education Coordinating Board

Baylor awarded $20 million for prostate cancer research

BAYLOR COLLEGE OF Medicine in Houston has been awarded a $20 million grant from the National Institutes of Health (NIH) to establish a program to develop new ways to diagnose, prevent, and treat prostate cancer.

The grant, awarded through the National Cancer Institute, the cancer research arm of the NIH, will fund an effort to create Specialized Programs of Research Excellence (SPORE) to study and treat various forms of cancer. Baylor and Johns Hopkins Hospital in Baltimore are the only two centers in the country funded by NIH to study prostate cancer.

The center will be designated the Matsunaga-Conte Research Center after US Sen Spark Matsunaga of Hawaii and US Rep Silvio Conte of Massachusetts, both victims of prostate cancer.

The SPORE team at Baylor, headed by Peter T. Scardino, MD, chairman of the urology department, will explore new ways to transfer re-

Mark Richardson, *associate editor, writes and edits the Science and Education and Medical Economics sections of* Texas Medicine.

TSBR sponsors student essay contest on research

THE TEXAS SOCIETY for Biomedical Research (TSBR) is sponsoring its first-ever student essay contest for high school junior and senior students across Texas. Science students are invited to submit an essay on the topic: "Why Animals Are Important to Biomedical Research."

According to Lorraine Hough, TSBR acting executive director, the contest is designed to encourage students to learn more about the importance of animals to biomedical research.

"We hope that as these students do research into the subject matter, they will not only learn some things about medical research but also gain a better understanding of how important animal research is in helping doctors cure disease," she said. "We hope physicians will help students by being a good source of information on medical research and encourage them to enter their work in the contest."

Science teachers are encouraged to discuss medical research with their classes and have students write and enter their essays as a class project. Essays must be typed, double-spaced, and approximately 500 words in length. They will be judged on content and form. Two first-place prizes of $500 and three second-place prizes of $250 will be awarded.

Each entrant must be a junior or senior in a Texas high school and must include his or her name; the name, address, and telephone number of the student's school; and the name of the science teacher.

Entries should be sent to TSBR Essay Contest, 401 W 15th St, Suite 690, Austin, TX 78701, and must be postmarked by January 8, 1993. Late entries will not be accepted. For more information, contact TSBR at (512) 370-1660.

search to patient care.

"This program will enhance the already extensive work being done at Baylor," he said. "By turning discoveries in the laboratory into new ways to treat and prevent prostate cancer, we can quickly apply these breakthroughs to patients and save lives."

The NIH will support prostate cancer research and education in the fields of cell biology, medicine, biostatistics, endocrinology, pathology, biochemistry, and molecular genetics.

The SPORE team's key targets include finding ways to distinguish potentially fatal, rapidly growing cancers from less life-threatening cancers, testing new preventive drug treatments, and studying ways to alter the prostate's immune system.

Prostate cancer is the second leading cause of cancer-related death in American men. Each year more than 34,000 men die from the disease, and more than 100,000 new cases are diagnosed annually. Statistically, African-American men have the highest rate of disease.

"The designation of Baylor as a national prostate cancer research center builds on the urology department's already solid research foundation," said William T. Butler, MD, Baylor president. "This level of funding reflects the high quality and competitiveness of research in this important area."

In 1989, Baylor was one of only three US medical schools selected to receive a 4-year NCI grant to determine how ultrasound and other new diagnostic procedures can detect prostate cancer in the early stages.

Researchers study microbes as substitute for animal testing

A METHOD OF TESTING pharmaceutical drugs that might, in some cases, substitute microbial cells for laboratory animals is under study by researchers at The University of Texas at Austin College of Pharmacy.

The technology proposes to use fungi for the study of the metabolism rate of drugs. Though not entirely intended to replace the use of mammals such as rats and guinea pigs for the testing of drugs, the use of fungi could reduce the overall need for lab animals, according to Patrick J. Davis, PhD, a professor of medicinal chemistry.

"The ultimate benefit would be the availability of an easily handled, nonmammalian, very predictable system for facilitating the development of drugs," said Dr Davis, who has worked on the project for 10 years.

The technology grew out of the use of microorganisms in organic synthesis, when researchers discovered a select group of fungi, *Cunninghamella elegans*, that have the ability to metabolize a wide variety of drugs in a way that is similar to humans. Metabolic studies must be done by drug companies to demonstrate the structure of the metabolite, to see if the metabolites have the same activity as the drug itself, and to see if the metabolites are toxic.

According to Dr Davis, the application of the microbial system under development would be most advantageous in the early stages of drug testing when little is known about how the drug is metabolized.

An advantage of using microbes would be an easier, faster, and less expensive "laboratory scale-up" of metabolites for identification and biological testing. Some toxicology studies might be carried out entirely with fungi, since the formation of toxic metabolites should give a measurable, toxic response in the microorganisms.

He adds that these methods, if effective, could help pharmaceutical companies address concerns about the use of animals in biomedical research.

"This should result in a reduction in animal demand, but will certainly

not substitute for doing all animal testing," he said. "You must eventually look at metabolism of each new drug in animals, just as you must eventually look at its metabolism in people before you administer the drugs on a routine basis to patients."

Studies to determine if a drug actually yields the physiological effects for which it is intended will probably always require testing on both animals and humans, he said.

"What we stress is that this is a model for predicting drug metabolism. We don't want to make claims that this is a method for determining whether a drug will have the intended pharmaceutical effect," he said.

The researchers have already tested the fungi on a variety of drugs, including anticoagulants, diuretics, anticonvulsants, and hemohelogic agents, and are working with a number of drug companies to determine the best means of applying the microbes to drug development. ★

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Crossword puzzle on p 80.

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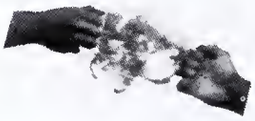

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Law

AMA, FBI establish health-care fraud hotline

PHYSICIANS NOW HAVE A LINK with the Federal Bureau of Investigation (FBI) to report cases of health-care fraud.

The American Medical Association has been working with the FBI on the issue of health-care fraud and at a recent meeting between the two organizations, FBI staff acknowledged that physicians are only rarely engaged in fraud and therefore are not the FBI's primary targets. Physicians are, however, often in a position to identify health-care fraud and to report it.

In cooperation with the FBI, the AMA's member services number, (800) 262-3211, has been designated as a fraud hotline. Once a suspected case of fraud has been reported by a physician or a medical society, the AMA will provide the information to the FBI. It is especially important that physicians report invitations to engage in fraudulent activity, such as a kickback offered by a medical equipment supplier.

TMA legal publications answer tough questions

LEARNING THE RULES AND regulations pertaining to the practice of medicine can seem like a never-ending task.

To ease the burden, the Texas Medical Association Office of General Counsel has developed two publications on laws pertaining to medical staff hearing processes and illegal remunerations.

- "The Medical Staff Hearing Process" answers questions on hospital medical staff privileges, reporting under the Health Care Quality Improvement Act, Data Bank procedures, defending clinical privileges, hearing rights, closed and open staffs, and responsibilities in credentialing. Nineteen forms are included as a resource for language in drafting documents needed to carry out professional review actions. To order, send $59 to TMA, Practice Management, 401 W 15th St, Austin, TX 78701-1680.

- "Payment for Referrals: A Compilation of Pertinent Laws and Statements on Ethics Relating to Illegal Remuneration" covers Texas and federal laws that pertain to illegal remuneration. It describes how the laws affect physicians' business relationships. To order, send $27 (for TMA members) and $43.20 (for nonmembers) to TMA, Practice Management, 401 W 15th St, Austin, TX 78701-1680.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

Accessibility key to compliance under ADA

Hugh M. Barton, JD
TMA Assistant General Counsel

All "public accommodations" — including hospitals and physicians' offices — are obligated to remove architectural barriers in order to accommodate physically disabled patients under the Americans With Disabilities Act (ADA).

Q: What specific law requires barrier removal?

A: Actually, two statutory provisions bear on this issue. The ADA's "general rule" concerning the prohibition of discrimination by "public accommodations" is as follows:

> No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases, (or leases to), or operates a place of public accommodation (1).

In addition to the general rule, the statute contains a list of "specific prohibitions" that are deemed to be violative of the general rule. These include the failure to remove architectural and communication barriers that are structural in nature in existing facilities if removal is "readily achievable" (2). Where barrier removal is not readily achievable, then a failure to make goods, services, and accommodations available through alternative methods that are readily achievable is also violative of the general rule (3).

Q: When is barrier removal considered "readily achievable?"

A: Barrier removal is considered "readily achievable" when it is "easily accomplishable" and can be carried out without much difficulty or expense (4).

Q: But how does the government determine what this really means?

A: A number of factors are considered, such as:

1. the nature of the modification and its cost;
2. the medical practice's overall financial resources and the im-

LEGAL NOTEBOOK

The following amicus curiae brief was filed by the Texas Medical Association's Office of the General Counsel. "Friend of court" briefs are filed in state or federal court when the outcome of a proceeding will have a substantial impact on Texas physicians and their patients. Amicus briefs are normally filed at the appellate level after the facts have been determined and the law applied at the trial level. The case is evaluated based on whether or not the facts present a genuine opportunity to support or defend an issue of common concern to the members generally and important to medicine.

• *Abuabara v Curry*

A Texas physician filed suit against two other physicians alleging the defendants misused the peer review process at the hospital in a thinly disguised attempt to harm his business.

Although the plaintiff physician was not actually disciplined by the hospital medical staff, he did receive a letter stating the intent to discipline. The letter was sent by the defendant, chairman of the surgical audit committee. The other defendant, the immediate past chairman of the committee, was a member of the committee when the disputed action took place.

Following review of one patient's treatment, the committee recommended that the physician's privileges be restricted as follows: surgery only with a board-certified surgeon present assisting and with a required telephone consultation prior to surgery. These restrictions never actually took place because the doctor challenged the decision and the matter was dropped at a higher level. No hearing was conducted. The hospital has not been formally sued as a defendant.

During the discovery phase of the lawsuit, the plaintiff's attorney attempted to ask some of the physicians involved in the peer review process about what they discussed during the process. Defense counsel objected that such information was confidential. The plaintiff's attorney filed a motion to compel and the judge ruled that the peer review information was discoverable.

If civil rights or anticompetitive claims are alleged, the Medical Practice Act provides that peer review discovery protections do not apply, but no other exception from discovery is included in the act. Nevertheless, the judge reasoned that the peer review information is discoverable because the plaintiff alleges that the defendants acted with "malice." Malice is not a statutory exception to confidentiality, but if malice is proven, the peer review immunity protections do not apply under Texas law.

A mandamus action requesting the San Antonio Court of Appeals to reverse the trial court's discovery order was filed by the defendant doctors.

TMA's amicus curiae brief argues the need to preserve confidentiality of peer review records and proceedings under Texas law. It supports the position that even though the reviewing physicians are charged with bad faith or malice, records and proceedings of hospital medical staff peer review committees should remain confidential and not be discoverable by the reviewed physician. It is sound public policy to foster peer review in an atmosphere free of the threat of discovery in a lawsuit, says the brief.

The brief concludes that it would be in the best interest of patients in Texas for the Court of Appeals to issue a mandamus requiring the trial court to reverse its order to release such records and to allow continued questioning of witnesses about the proceedings of the peer review committee.

pact of the modification on the operation of the practice;

3. the number of persons employed by the medical practice and the overall size of the practice; and
4. the nature of the practice itself, such as the specialty (family practice v orthopedics) and the type of operation (psychiatrist's office v imaging center).

Q: What are some examples of modifications that the government considers to be readily achievable?

A: Modifications include installing ramps over a few steps (though not over an entire flight of stairs); creating designated accessible parking spaces; making curb cuts in sidewalks; rearranging furniture; installing a raised toilet seat; repositioning the paper towel dispenser in a restroom; installing accessible door hardware; and installing grab bars in toilet stalls (5).

Q: Will my medical office building have to install an elevator if it does not already have one?

A: No. There is no requirement to retrofit a building by installing an elevator, unless the installation is "readily achievable," which is unlikely in most cases (6). However, elevator installation is required in new construction or in buildings that are being substantially altered (7).

Q: Must I remove all objectionable barriers in areas of my office that are only used by physicians and staff, such as lab areas, storerooms, and private offices?

A: No. The purpose of Title III of the ADA is to ensure that public accommodations are accessible to customers, clients, and patrons, as distinct from employees. The official comments to the final regulations state that "the obligation to remove barriers . . . does not extend to areas of a facility that are used exclusively as employee work areas" (8).

Q: I rent office space in a large medical building. Who is responsible for barrier removal, my landlord or me, when the office is remodeled?

A: The general rule — quoted above — provides that the obligation falls on anyone who "leases, or leases to"

a place of public accommodation, indicating that the primary obligation is on the tenant. However, it may be possible to negotiate a cost-sharing of such expenses, since any changes you make to achieve ADA compliance ultimately benefit the landlord by making the office space more attractive to future tenants.

Q: Does a doctor's office have to provide patients with wheelchairs?
A: No. There is no requirement to provide "personal devices" such as wheelchairs or crutches or to provide assistance with toileting or dressing (9).

Q: My group is thinking about constructing a new building or perhaps adding a new wing to our existing building. What ADA considerations must we consider?
A: Newly constructed facilities designed and constructed for first occupancy after January 26, 1993, must be "readily accessible to and usable by individuals with disabilities" except where meeting that standard is "structurally impracticable" (10). Only where "the unique characteristics of terrain prevent the incorporation of accessibility features" will it be possible to show structural impracticability (11). This means that the facility can be approached, entered, and used by disabled persons easily and conveniently (12). The specifics of accessible design in new construction are set forth in the document "ADA Accessibility Guidelines for Buildings and Facilities" (13). This document is available from the Office of the Americans with Disabilities Act, Civil Rights Division, US Department of Justice, PO Box 66118, Washington, DC 20035-6118, telephone (202) 514-0301.

Not every feature of new construction must be accessible. In order to be readily accessible, such areas as street entrances, doorways, restrooms, waiting rooms, and the like must be considered. As stated above, work areas are not covered, nor do such areas to which access is required for maintenance and repairs need to be accessible to the disabled if the essential functions of the work performed in those areas require physical mobility (14). Additionally, not all public entrances to a new building need to be accessible, so long as at least 50% are accessible (15).

Q: Will it be expensive to make these changes?
A: It shouldn't be, at least in the view of the US Department of Justice, which has stated:

> The cost of incorporating accessibility features in new construction is less than one percent of construction costs. This is a small price in relation to the economic benefits to be derived from full accessibility in the future, such as increased employment and consumer spending and decreased welfare dependency.

THE INTERNAL REVENUE CODE ALLOWS A DEDUCTION OF UP TO $15,000 PER YEAR FOR COSTS OF BARRIER REMOVAL.

Q: What if we just alter our existing facility?
A: Accessibility is still required. If a commercial facility of public accommodation is being altered on January 26, 1992, or is altered after that date in a manner that affects the usability of the facility, the altered portion of the facility must be reasonably accessible to and useable by individuals with disabilities (16). An alteration that "affects usability of the facility" and therefore creates a compliance requirement is broadly defined. Only such minor items as painting walls, changing wall coverings, repairing the roof, doing plumbing, heating, and air conditioning repairs (without changing systems), and similar routine maintenance are excluded as alterations that trigger the requirement (17).

Several examples can be suggested. If a restroom is modified, it must be made to fully comply with the "readily accessible" standard. If a floor covering is changed, the new floor covering cannot make access in wheelchairs difficult. If a corridor is renovated, the drinking fountains along that corridor must comply with the regulations.

The law also contains a provision concerning alterations to "an area of the facility containing a primary function." If an alteration is to the "primary function" of the facility, then not only the area of the "primary function" but also the "path of travel" to the altered area and the restrooms, telephones, and drinking fountains serving the altered areas must be made "readily accessible to and useable by individuals with disabilities unless the cost of alteration is disproportionate to the cost of overall alteration." The cost is disproportionate if the cost associated with the path of travel alterations is more than 20% of the cost of alteration to the primary function area (18).

Q: How do I achieve barrier removal in the office?
A: The regulations recommend a "staged" or "phased-in" plan to

achieve barrier removal and to serve as evidence of good faith efforts to comply with ADA requirements. The regulations urge that priority be given to certain measures.

One priority should be access from sidewalks, parking, or public transportation. Examples include installing entrance ramps, widening entrances, and widening designated parking spaces.

Another priority should be access to areas in which patients are seen. Examples include adjusting the layout of display racks, rearranging tables, providing braille and raised character signage, widening doors, providing visual alarms, and installing ramps.

An additional priority should be access to toilet facilities. These measures include removing obstructing furniture or vending machines, widening doors, installing ramps, providing accessible signage, widening toilet stalls, and installing grab bars (19).

Q: Are these costs tax-deductible?

A: The Internal Revenue Code allows a deduction of up to $15,000 per year for costs of barrier removal. Certain tax credits also exist for those practices that qualify as a "small business."

Q: Is compliance with the ADA an ongoing obligation?

A: The obligation to remove barriers is a continuing one. Thus, a barrier removal that was not readily achievable initially may later be required due to changed circumstances. However, no sort of annual assessment or self-evaluation is required. It is advisable when considering changes to consult with disabled patients about the problems they encounter in your office (20). Finally, note that the requirements for barrier removal in existing structures are much less rigorous than those for new construction and alterations (21). Thus, it is not necessary to take more complicated steps if you are not planning a new building or major renovation.

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out of harm's way

real help for addicted physicians

For decades, the drunk made a great cartoon character. Wobbling down the sidewalk, tipping his hat to a light pole, offering a cop a drink, blissfully unaware of the car that narrowly missed him, he was an easy target for our laughter.

But though we are less likely to laugh at addiction today, we are still so skeptical of its treatability that we hesitate to admit that our uncle, neighbor, or colleague may need help. The medical profession, too, struggles to acknowledge the existence of addicted physicians and to see their plight as anything more than a behavior problem or a private moral failure.

And yet, the data demand our attention: physicians suffer from addiction in about the same proportions as the general public. Estimates are that at least one in 10 will face it at some point in their lives.

For this article, Texas physicians and others talked about recognizing and treating alcoholic or drug-addicted physicians. Those interviewed are experts — either because of personal experience with chemical dependency or because they work with the Texas Medical Association's Committee on Physician Health and Rehabilitation and various county medical society programs.

The message comes through loud and clear: "There is a problem, but we can help. We are a confidential advocate for the impaired physician, not a punitive agent. No physician need suffer in silence. With appropriate treatment and follow-up, prognosis is excellent."

Kathryn Trombatore, Director, TMA Division of Communication

ADDICTED DOCTORS have no corner on the denial market.

Their colleagues give a host of reasons for not confronting impaired peers, and each one makes a kind of sense:

"I couldn't be the one to make him lose his license."

"She only drinks at night . . . and never when seeing patients."

"Well, he's going through a rough time — 24 hours on, 12 off."

"I'm not about to lay myself open to a lawsuit."

The tendency to deny that a colleague is impaired is particularly strong among physicians, say addiction experts, because they are schooled to see themselves as invincible. Some also assume that their medical knowledge, especially of pharmacology, is a shield against the consequences of abuse.

Ironically, those factors can contribute to a physician's choosing alcohol or drugs as a way to cope with an impossible life. Physicians push their physical and mental capacities to the limit continuously. They have no time to be sick, no time to be tired, no time to let down. They work in a state of sustained stress, which in tandem with personality and genetic factors may open the door to chemical dependence.

The need to be invincible also can prevent physicians from asking for help before their addiction progresses to devastating levels.

"One of the things that makes physicians so extremely vulnerable to the *progression* of this disease is that it is so difficult for them to imagine that they might need help," says Dennis Dalton, MD, a Dallas psychiatrist who is a consultant to the Substance Abuse Program at Timberlawn Hospital and to the Texas Medical Association Committee on Physician Health and Rehabilitation (PHR).

The official term for not recognizing addiction in oneself or others is well-known: denial. In fact, it is a hallmark of the disease.

"Alcoholism is the only disease I know that tells you that you don't have it," wrote a physician in a recent issue of the *Dallas Medical Journal* (1). "I pictured myself and presented myself as just a nice guy who, unfortunately, drank too much."

Family members, too, often either deny that a problem exists or they become adept at covering for the impaired physician to protect the family's social status and livelihood. In addiction parlance, they "enable" the addiction to go undiagnosed and untreated.

"Until the final stages of my drinking, to my knowledge, no one even suggested to me that there may have been a problem, and I certainly couldn't recognize the problem in myself," wrote the physician-author quoted above.

Given, then, that addicted physicians almost never voluntarily seek treatment until very late in the disease, their rescue depends heavily on colleagues learning to recognize the disease and to take effective action.

what does it look like?

MANY PEOPLE HAVE wished for some squared-off, precise way to tell if they or others are addicted. Just where is the line between "moderate" and "impaired"?

The answer isn't given in drams or liters.

The absolute amount of alcohol or other drugs consumed daily is not a reliable way to distinguish addiction, says G. Douglas Talbott, MD, founder of a well-known addiction treatment program in Georgia.

"Degree of intake alone does not determine whether one becomes diseased," he wrote in a recent article (2). "It is the genetic predisposition in the face of abuse that is needed to cross the biogenetic wall. For every addict, there are individuals who have used larger quantities of the drug over longer periods of time. Yet the latter group does not demonstrate compulsive lack of control over drug intake."

In other words, not all abusers become addicts. While drug or alcohol *abuse* can lead to major medical problems, even death, it is the compulsive lack of control over the drug or alcohol use that is most characteristic of *addiction*.

The social stigma still attached to this diagnosis exists in spite of the fact that nobody starts drinking or drugging to become addicted. Alcoholics started drinking for the same reasons that healthy drinkers do, but they tend to experience alcohol in an unusual way.

"I just know that if everybody felt the way I did when I drank alcohol, everyone would become a drunk," says one physician.

The definition of alcoholism now most widely accepted is:

Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic (3).

While that helps clarify that alcoholism is a disease (and experts say the definition also applies to other drug addictions), most people trying to decide if a physician is chemically dependent want a list of "symptoms" specific to physicians. (See box, next page.)

However, Edgar P. Nace, MD, associate executive medical director and medical director for substance abuse programs at Green Oaks Hospital in Dallas and chairman of TMA's Committee on Physician Health and Rehabilitation, says doctors often are recognized as chemically dependent the same way other people are. "They may get a DWI for example. Or, a medical compli-

Illustration and hand-lettering by Matt Lynaugh.

signs and symptoms of addicted physicians

WHILE MANY OF THE FOLLOWING signs can occur outside of addiction, anyone who displays more than a few of them should be evaluated. (Adapted from "Impaired physicians: the dilemma of identification." *Postgrad Med.* 1980;68 [6]56–64.)

family
Withdrawal from family activities
Unexplained absences
Fights, child abuse
Abnormal or illegal behavior by children
Sexual problems
Financial problems
Separation or divorce

community
Withdrawal from activities
Loss of friendships
Embarrassing behavior at social functions
Arrests for driving while intoxicated
Unpredictable behavior

employment
Numerous job changes
Frequent, unexplained geographic relocations
Unexplained intervals between jobs
Job inappropriate for qualifications

physical status
Deterioration in appearance
Multiple physical signs and complaints
Numerous prescriptions and drugs
Signs of intoxication
Accidents
Emotional crises

office
Appointment schedule disruptions
Hostile or withdrawn behavior
Complaints from patients
Unexplained absence from office
Orders excessive supplies of drugs
"Locked-door" syndrome
Inappropriate orders

hospital
Making rounds at inappropriate times
Abnormal behavior during rounds
Inappropriate orders
Unavailability to emergency room or call
Charting deteriorates, handwriting changes
Malpractice suits, legal sanctions
Staff allegations of inappropriate behavior

cation may show up: elevated liver enzymes on a physical exam, for example. Or they might develop withdrawal symptoms."

Alcoholism may be preceded by years of excessive drinking and may run an insidious course. Indeed, that course can be measured in months for some people and in years or even decades for others. It may begin during adolescence, college years, or during social activities with colleagues.

In fact, *when* it begins helps distinguish between types of addicts.

two types, but similar tragedy

"GENERALLY WE SEE two types of chemically dependent physicians," says Dr Nace. "One type fits into the category of adjustment disorder: the person has been under stress — professional, personal, or a combination — and begins to self-medicate." He says that while these physicians have not been good at taking care of themselves, they do not have a "trail of trouble" behind them. They tend to respond well to treatment.

The other type of addict, says Dr Nace, began using drugs or alcohol in adolescence and continued throughout medical school and residency. At some point, they developed a full-blown dependency. "They tend to be more resistant to treatment, more manipulative, and they need a lot of very careful monitoring to assure they comply with treatment recommendations," he says.

These two groups generally correspond to the type A and type B alcoholics discussed in an article in the *Archives of General Psychiatry* earlier this year (4). Distinguishing between the types can help in planning treatment, but the progressive symptoms of the two are the same. They include amnesia or blackouts, surreptitious drinking, and preoccupation with alcohol such as being concerned about an adequate supply. Loss of control becomes a problem as the disease progresses. Most addicts try repeatedly to cut down or stop on their own.

Depression and/or anxiety frequently complicate the picture and may mistakenly be identified as primary psychiatric disorders instead of secondary complications. Most experts agree that treating psychiatric conditions or personality problems before dealing with addiction simply doesn't work.

With the disease's continued progression, changes appear in all aspects of the physician's life. Their medical practice, however, is usually the last place impairment is noted. Because being a physician is so central to their lives, most addicted physicians are able to practice adequately until fairly late in the disease.

"The last skill an addict loses is the thing he knows best," says Eugene Seale, MD, medical director of Starlite Village Hospital, a treatment facility near Kerrville. "He may not learn new things very well, but the things he does almost by rote he can continue to do." He tells of physicians who were called to their hospital, diagnosed appendicitis in a patient, operated, returned to the hospital the next morning, and did not remember it. "The physician may have made the diagnosis correctly and the patient was okay, but he was in blackout when he was operating. I wouldn't say that is happening all the time, but it does happen."

why wait for disaster?

UNFORTUNATELY, MOST addicted physicians' ability to function adequately as doctors can make it very hard to identify them before destruction is widespread in other aspects of their lives. But colleagues should not wait for conclusive evidence before offering to help.

"The old adage that 'where there's smoke, there's fire' is really applicable to this disease," says Dr Dalton, who chairs the Impaired Physicians Committee at Parkland Memorial Hospital. He says people don't generally talk about an individual's drinking or drug use unless a problem exists. He calls it "Dalton's Law": Whenever anyone

who cares about another individual raises the question of his drinking or drug use, it deserves careful evaluation by professionals trained to recognize and treat addiction.

Rudy Arredondo, EdD, consultant to the TMA PHR committee and associate professor of psychiatry at Texas Tech University Health Sciences Center, adds, "It's crucial that a physician who thinks a colleague is having a problem do something immediately. Early intervention is the key to a better prognosis." (But intervening even late in the disease is better than *never*, since addiction can be fatal.)

He also stresses that contacting the TMA hotline does not begin some lockstep procedure that always results in a physician being confronted. "If you're not sure, but there are a lot of red flags about a physician's behavior, go ahead and contact the committee. They never, ever, jump in without carefully investigating the allegation. Only if there is sufficient reason to intervene will they do so."

There are times, of course, when little doubt exists about whether a physician is impaired, and inaction in these circumstances angers formerly impaired physicians.

"Everybody knows that they're drinking like a fish, but they don't do a damn thing about it," says one physician now in recovery. "And they end up dead. If you're concerned about someone, I think you've got an obligation to address it."

Dr Seale, a former consultant to the TMA PHR committee, agrees. His hope is that this article will prompt more physicians to take action.

"Encourage the readers not to wait until the guy kills himself in a car wreck or gets so low that he shoots himself," he says. "Some of them drink themselves into a corner. They don't see any way out, and they will kill themselves. The only thing it takes to prevent that is to show them an alternative and they'll take it. It's amazing how simple it is."

While some addicted physicians initially respond to even the most carefully planned "interventions" with denial and anger, most who have begun to recover share this physician's sentiment: "There's nothing else like having somebody say, 'I know what's wrong with you, and you don't ever have to drink again. You don't ever have to feel this bad again. We can save your life. Let me help you.'"

Hospitals, too, can and should respond to impaired physicians, says Georgia A. Thomas, MD, MPH, a member of the TMA's PHR committee. She is director of the employee health service and assistant professor in the division of medicine at The University of Texas M.D. Anderson Cancer Center. "In an ideal circumstance, you have an alert, aware hospital staff. You've educated not only your physicians, but administrators, about chemical dependency. They are alert for warning signs of a physician in trouble: just something as simple as handwriting that changes dramatically or notes that don't make any sense.

"All hospital staffs need some kind of mechanism for pulling a physician aside and saying, 'We are worried for you. Something is impacting your ability to see patients and we're going to help. We want you evaluated by somebody who understands physicians and impairment. We're not going to let you disintegrate. We insist.'"

Taking action in the case of an impaired physician protects not only patients, but also the health of the doctor. However, many physicians are afraid they might unjustly deprive colleagues of their livelihood if

how many doctors are impaired?

For years, there was a popular belief that physicians were more prone to addiction than the population as a whole. Yet scientific data to demonstrate this contention have been lacking.

Indeed, recent research indicates that while physicians are more likely to *use* alcohol and prescription drugs than the general public, they are not any more likely to *abuse* them or to become addicted.

Earlier this year, *JAMA* reported that physicians are far less likely to use illegal drugs than the general public, but more likely to use alcohol and prescription substances.* The research was based on physicians who self-reported use of 13 substances. Not surprisingly, few admitted ever having abused substances. The rate of heavy, daily use of alcohol reported was 0.6%; of benzodiazepines, 0.5%; and of major and minor opiates, 0.2%.

A similar survey of resident physicians was reported in 1991.† Heavy substance use patterns were not observed. Residents used psychoactive substances at significantly lower rates than their peers in the general population, but they reported higher rates of past-month use of alcohol and benzodiazepines.

Despite the positive news from these studies, many experts believe physicians generally suffer from the same problems that other people do, at about the same rates. They stress that 10% is a conservative estimate of the lifetime prevalence of addiction among physicians and the general public. (According to this estimate, about 3,000 physicians now in Texas face addiction at some time during their lives.)

"The number of people who have either alcohol abuse or dependence at some point in their lifetime is 13.9%," says Edgar P. Nace, MD, chairman of TMA's Committee on Physician Health and Rehabilitation. "For drug abuse or drug dependence, it's about 6%." Since drug and alcohol use can overlap, estimates are that the lifetime prevalence for someone to have a substance use disorder (either abuse or full-blown addiction) is about 16%.

* Hughes PH, Brandenburg N, DeWitt C, et al. Prevalence of substance use among US physicians. *JAMA*. 1992;267:2333–2339.

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the hotline:
(512) 370-1640

ANSWERED BY A RECORDING, the 24-hour hotline of the TMA Committee on Physician Health and Rehabilitation is the key to a completely confidential program that acts as an advocate for impaired physicians, rather than as a punitive agent.

Anyone concerned about a possibly impaired physician may call. Some county medical societies also have hotlines for impaired physicians and about 75 have local committees.

While most callers use the hotline to report problems with addiction, the committee also can help physicians with impairments caused by psychiatric problems, cognitive disorders, aging, AIDS, or compulsive behaviors such as gambling.

Referring a colleague is not betraying a trust, say committee members, but acting responsibly to contain and prevent the problem of impairment. They point out that particularly in the case of addiction, you are *saving* a career and possibly a life, not ending it. With appropriate treatment and follow-up, addicted physicians have a very high rate of recovery.

One physician, in describing why he agreed to talk to *Texas Medicine* about his addiction, said, "I have a motive for this. There are a lot of guys out there right now who are hurting real bad. They shouldn't have to wait as long as I did for treatment."

they raise the issue. Quite the opposite is true, says Dr Nace.

"My experience has been that doctors who get into recovery do not suffer economic loss," he says. The ramifications for the physician's practice are much more severe if the chemical dependency goes untreated. "If they get help, they preserve their health, their career, and usually their family life."

clearing the legal hurdles

NO SMALL PART OF doctors' hesitation in confronting colleagues has been their fear of retaliation.

The prospect of a colleague angrily denying that a problem exists, charging his or her accuser(s) of self-serving economic interest, and filing suit can intimidate the most concerned physician into silence.

But Donald P. Wilcox, JD, TMA general counsel, says the fear is unjustified. He knows of only a couple of suits filed in the last 12 years in Texas along these lines and neither has resulted in a judgment against the reporting physicians or their committee. "It's a common threat, but 99% of the time it doesn't come to fruition," he says.

Amendments added to the Medical Practice Act of Texas in 1987 significantly strengthened the protection for both peer review and physician rehabilitation committees so that "good faith reporting" is protected.

Mr Wilcox also pointed out that TMA has worked to minimize the chance that committees would make mistakes in identifying impaired physicians, but "even if a mistake was made, if everybody had acted in good faith and tried to do the right thing, they would be protected from any judgment."

The real threat of legal action, he says, comes not from reporting an impaired colleague, but from failing to do so.

A physician or hospital committee with knowledge of a colleague who poses *a continuing threat to the public welfare* (as opposed to one who is possibly addicted but represents no danger to patients) is *required* by the Medical Practice Act to report that person to the Texas State Board of Medical Examiners.

Mr Wilcox has not heard of the board taking disciplinary action because of a failure to report, but there have been cases in which colleagues of an impaired doctor were successfully sued by the doctor's injured patient.

One well-known 1989 case cost the colleagues of a Fort Worth anesthesiologist, Garry E. Winn, DO, $5 million when a jury decided they should have known he was impaired and should have removed him from their hospital staff. The doctor's hospital, its chief of staff, and two former partners, each of whom had headed the anesthesiology department during a period critical to the case, were found liable.

Colleagues and committees should take appropriate action well before the need to report to the board of medical examiners, says Mr Wilcox. He adds that reporting through the TMA or county medical society physician rehabilitation committees makes both good business and ethical sense.

Physicians in partnership are generally held liable for the acts of other partners, says Mr Wilcox, and professional associations face similar risks. Even limited liability partnerships, established to limit a variety of risks, still endanger the assets of the business if an impaired partner is allowed to continue practicing without treatment.

what can you do about it?

WHILE EXPERTS ARE unanimous in recommending that help be tendered to possibly impaired physicians, they differ somewhat in the exact approach they encourage.

Some say colleagues should talk directly to the doctor about whom they are concerned. Others think that is best left to those trained to intervene.

"I think it's very appropriate for the doctor to confront the other physician him- or herself," says Dr Nace. But it is important to cite specific examples of problems, including times, places, and behaviors, rather than to casually ask whether a person is "having trouble."

"I'll give you an example of two physicians who successfully confronted the third physician in their partnership recently. They said, 'You have 60 charts that haven't been dictated. You come into work late. You're not as sociable as you used to be. There is a change in your behavior and your attitude. We think something is wrong.' They had already checked with the local pharmacist and found that their partner had been obtaining substantial quantities of medication for himself.

Sober, nobody can hurt me

I WAS THE FIRST MEMBER OF my family to go into recovery. Everybody else died from this disease.

I had been fully addicted to drugs and alcohol since college, probably since high school. My parents died in 1981 and 1982 and that pretty much pulled the rug out from under me. The way I dealt with it was just to use more drugs . . .

In 1984, I went to a family program for a brother-in-law who was addicted to heroin. As I sat there for those 5 days, I understood what addiction really was. That was the first time that I really, really knew I was sick, but I figured I was smart enough and had enough willpower to quit on my own. So I made a promise to myself . . .

But, I flew back to Austin and immediately started using again. It took me a year to convince myself I couldn't quit. I was using five, six, or seven different drugs a day — cocaine, narcotics, methamphetamines, marijuana, alcohol, anything I could get my hands on, but by that time, the drugs weren't working anymore.

At that point, death was my best option. I didn't really care anymore. I was never suicidal, but it really didn't matter whether I lived or not. My fear was not of death. It was of being so miserable until I died.

The reports on my performance at work were wonderful, because I worked three times as hard to make sure I didn't make any mistakes. I had not worked in at least 5 years without being on speed. I was the guy who could go 24 hours and do the best laceration jobs and be wide awake at 4 am. . .

I remember sitting out on the driveway on May 15, 1985, my daughter's birthday. That night, I reached an emotional bottom that I'd never, ever felt before: I was late for my 5-year-old daughter's birthday party because of drugs.

I promised myself that night that I was going to quit, but that if I didn't, I would get some help. That last part was new.

My birthday was 2 days later and that was my date to quit. But a friend handed me some pills as a birthday present. He said, "Here's this thing called Ecstasy." And I took it without any thought about my promise or the consequences. But it was like an electrical shock and I knew it was time to ask for help.

I walked up to my wife and said, "I have a drug problem. I need to get some help."

By then, I had drugs hidden everywhere . . . a lot of them were given to me by pharmaceutical representatives. My wife was stunned. She just couldn't believe it.

Two days later, I was flying into Atlanta, Ga, and it has all been different since.

But I didn't really go to Atlanta to get sober. I only wanted to get off cocaine and narcotics and methamphetamines. They kept me for 4 months and I thank God for that because I learned that what these people were telling me was the truth — that I could never, ever successfully use drugs again.

But to simply quit drugs was intolerable, because they were my best friends. I loved them better than my wife and my kids. It took me a long time to understand that I had to replace them with something, and that was Alcoholics Anonymous.

I can't stay sober without AA. I'd like to think I'm smart enough to stay sober, but the truth is that intellect can be your biggest barrier to getting sober. When I think I'm doing so damn well, I need to go to an extra few meetings. I still go to at least three a week.

Sober, nobody can hurt me. Sober I have my license. Sober I can work. I'm just happy to be alive. It takes a long time to come around to that. I based my happiness on the size of my house and my cars. But without being sober, you're guaranteed to lose it all . . .

After my treatment, I drove a 1962 Chevy II that had no floorboard in it. I put plywood over the holes. And I swear to God I had more fun driving that thing.

As a result of their talking to him, the partner said, 'You're right. I've got a problem.'"

Dr Nace acknowledges that not all impaired physicians accept help when first confronted. When faced with an angry and resentful doctor who may be impaired, he suggests emphasizing that "I am concerned for you and for our partnership (or for our hospital). I'm not here to make a diagnosis, but I want you to have an evaluation."

He cautions that because most colleagues of an impaired physician are hoping they are wrong about the diagnosis, they are in danger of being falsely reassured. "You need a backup plan in case you are stonewalled, stymied, or snowed," he says.

Alternately, he warns against adopting an attitude that is too heroic or zealous, which can increase the chance of a physician being falsely identified as impaired.

Although Dr Nace thinks it can be appropriate for doctors to "take the first step" with a possibly impaired colleague, he admits that most probably will prefer to call the TMA hotline or to contact a county medical society or hospital committee.

Dr Dalton is among those who believe this is *always* the preferred approach. "It's extremely important to ask for help from somebody who is an expert in providing the type of intervention that is necessary," he says, because colleagues are not well prepared to deal with the denial and rationalization they are likely to encounter.

"If you say to somebody, 'You have a problem with alcohol or drugs or both,' the individual first says 'No I don't.' If you persist, he says, 'Besides that, I can control it.'

Texas Medical Association Committee on Physician Health and Rehabilitation

Edgar P. Nace, MD, Dallas, Chairman

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Dennis Dalton, MD, Dallas
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Manish Patel, Houston
Student representative
Arthur Benzick, Houston
Alternate student representative
Margaret Smith, Corpus Christi
Alliance representative

PHR assistance fund needs contributions

THE LOAN FUND THAT HELPS impaired physicians who are also facing severe financial problems is, itself, in critical condition. Over the years, the TMA Alliance has been the largest contributor to the fund, but a broader base of support is needed. If you can help, send a check to the Physician Health and Rehabilitation Assistance Fund, Texas Medical Association, 401 W 15th St, Austin, TX 78701. Linda Kuhn, who coordinates the TMA PHR committee, can discuss the criteria for loaning funds and supply an application form. Her number is (800) 880-1300, ext 1342.

Next, you get something like, 'If you were married to her, you'd drink too,' which misses the point entirely," says Dr Dalton.

a confidential advocate for the impaired physician

MOST CALLERS TO THE 24-hour hotline of the TMA Committee on Physician Health and Rehabilitation (512-370-1640) want answers to two questions before they will proceed with the conversation, says Linda Kuhn, a TMA staff member who coordinates the committee:

"Is my name going to be used?"

"What's going to happen to my colleague?"

Ms Kuhn is quick to assure them that their names absolutely will not be used without their permission. She also makes it clear that, unlike the Texas State Board of Medical Examiners, which investigates possibly impaired physicians because of its statutory duty to protect the patient, the PHR committee was established in 1976 to rehabilitate, rather than to punish, impaired physicians. Only when a physician, through the practice of medicine, poses a continuing threat to the public welfare is a report to the board of medical examiners required.

Here's how the hotline works: the line is answered by a recording. Although callers may leave an anonymous message, Ms Kuhn recommends that they leave their name and phone number so she can more easily verify that the call is not a prank. However, as long as callers leave a clear message with the name of the possibly impaired doctor, his or her city, and the nature of the referral, the committee will follow up on it.

"It's just more work," she says, "to start from nothing and try to find someone who's willing to talk about the problem."

A caller who leaves his or her name and number will be contacted by phone about the referral. Ms Kuhn says it is helpful to know exactly what happened that motivated the person to call and who else might know of the physician's behavior and impairment.

(Although most calls to the hotline come from concerned colleagues or spouses, Ms Kuhn says occasionally a physician calls about him- or herself. When that happens, the committee can work very quickly and confidentially to secure help for the physician.)

After the committee gathers sufficient evidence that a call is not a prank, the name of the possibly impaired physician is given either to the PHR committee at the doctor's county medical society or to a PHR district coordinator if there is no local committee. (Each TMA councilor district has one PHR district coordinator who acts as a "circuit rider" and coordinator for activities within his or her district.)

About 75 county medical societies have PHR committees and many referrals go directly to them rather than through the TMA hotline. Typically, the committees are formed both of formerly impaired physicians and of physicians who have never been impaired.

Ms Kuhn says many doctors are more at ease being monitored by peers in their own geographic area who are familiar with the disease. Occasionally, however, a doctor does not want his local colleagues to know of the problem. In that case, arrangements usually can be made with a nearby society.

The local PHR committee or district coordinator discreetly investigates each referral received. If sufficient evidence of a problem exists, a very special meeting is arranged with the physician. That meeting, known as an intervention, often represents the physician's first step back to health.

the good news begins here

RATHER THAN WAIT FOR an addict to "hit bottom" and ask for help, most addiction experts now recommend trying to "raise the bottom." Interventions are designed to convince

addicts to enter treatment before they self-destruct.

In an intervention, a group of people, usually including family members and colleagues, present their concerns about how the disease is affecting the physician, his or her practice, and others. The goal is to get him or her into treatment or at least to receive a thorough evaluation.

Typically, much work goes into preparing an intervention. Physicians from the committee, one of whom is usually a recovering addict, choose other participants with intimate knowledge of the physician's behavior. They gather specific examples of the consequences of the physician's addiction. Names, dates, and details help to "break through the denial." (This is when permission to use a colleague's name can be beneficial.)

The key words to describe the atmosphere in an effective intervention are caring, objective, and nonjudgmental, says Dr Arredondo, of Texas Tech. If the event is too dramatic or punitive, it can provoke rage and resentment and greatly decrease the likelihood that the impaired physician will accept help.

"Sometimes the impaired physician responds to the intervention with anger, but frequently, because he or she has been suffering, it's a big relief that somebody is offering to help," Dr Arredondo says. Physicians are particularly relieved, he says, once they realize that the committee is not the Texas State Board of Medical Examiners and that this is an opportunity to salvage themselves, their families, and their practices.

Initial intervention efforts sometimes are spurned, however, and committees then usually arrange a second intervention. They make it clear early in the process that, although their approach is one of anonymity and advocacy, they won't just go away if the impaired physician chooses to defy their efforts.

Almost all addicted physicians who are confronted do, ultimately, sign a treatment agreement with typically at least a 2- or 3-year follow-up program.

the brave new (terrifying) world of sobriety

WHILE THE ROAD TO recovery for addicted physicians may seem hopelessly long and frightening, the hard work is worth it, says Herbert C. Munden, MD, a member of both the TMA PHR committee and the Travis County Medical Society's committee. Dr Munden is director of the adult chemical dependency program at Charter Hospital of Austin.

"The addict faces two paths," he says. "One is totally predictable because addiction never gets better until you deal with it. The other path, toward recovery, is scary as hell because it is unknown. But addicted physicians need to hear that they will be treated as human beings with an illness and that they can recover."

In fact, the prognosis is much better for addicted physicians who receive treatment than for alcoholics in the general public. Among the population as a whole, only about 50% of alcoholics who receive treatment are sober 2 years later. For physicians, more than 75% (some claim as high as 90%) maintain long-term sobriety.

Credit for that accomplishment may go to the fact that most physicians are closely monitored for at least 2 years after active treatment. Additionally, some experts believe physicians' motivation to remain sober may be stronger because they have more to lose: high status and a license to practice medicine are not easily regained.

what treatment works?

TREATMENT RECOMMENDATIONS vary, but many experts say an initial period of inpatient care is essential for physicians because they usually are in the later stages of addiction when identified.

Additionally, inpatient settings provide the intensity often required to dismantle the sophisticated denial systems of most chemically dependent physicians.

"There's a saying in Alcoholics Anonymous that there's nobody too dumb to do a successful AA program, but there are a lot of people who are too smart," says Dwight Ewing, MD, a Corpus Christi family practitioner active with the Nueces County Medical Society's PHR committee. "The problem is that physicians are so damned arrogant and intelligent and they're so used to telling people what to do that it makes them very difficult to treat. Nearly always, a physician who has a significant alcohol or drug problem is going to need inpatient treatment."

He and others say, however, that outpatient treatment can succeed if the disease is caught early and the physician's family is active in 12-step programs such as Alcoholics Anonymous and Al-Anon.

While a few experts recommend physician-only treatment programs, most say integrated programs help

addiction: the personal stories

i made the headlines

A LITTLE OVER 31 years ago, I had lost my license to practice medicine. I have to give people in those days credit. The Texas State Board (of Medical Examiners) did the right thing with me. I wasn't fit to practice medicine, so they took my license away. And when I sobered up and went back to them, they gave it back. To me, that's what should happen.

I was one of the people who had a tendency to get a lot of publicity. I made the headlines in my little, local paper for getting drunk and getting a DWI. The people up in Lubbock — the Alcoholics Anonymous people — started driving me to AA. They kept inviting me and I kept going to meetings. Fourteen years later, I finally admitted the first step — that when I take one drink, I couldn't consistently control the amount I drink. Under the influence of alcohol, those tragic things just kept happening until I had become a total failure at life.

I haven't had a drink since. It truly set me free.

there's something wrong with me

LET'S SEE, I'M A nice girl from a good family. I grew up in a small town in the Midwest and always wanted to be a doctor.

I had my first experience with my addiction when I was in 4th or 5th grade. I had to be hospitalized for a urinary tract infection and was given my first dose of an oral narcotic. I still remember how I felt from that drug. I couldn't believe that anybody could feel that wonderful. I have since come to recognize that that sense of feeling wonderful with a mood-altering agent does not occur with normal people . . .

I had my first pivotal experience with unlimited amounts of alcohol at a college fraternity party. My memory about how I felt at that party and what actually happened are so dissonant. What actually happened was that I got wildly drunk and ended up barfing all over the second floor roof of a dormitory. So it should have been an absolutely horrible experience. My memory of it is that I felt wonderful. For the first time in my life I really felt competent, intelligent, and beautiful. I wasn't too tall and too thin. I was finally everything that everyone expected me to be.

I was lost from that time on. Mine is a story of doing well for a while and then cycling through a period of either abusing drugs or drinking heavily . . .

I almost flunked out of medical school, but I had a good year of internship until I got involved in writing prescriptions for narcotics and got caught by the hospital . . .

I finished my residency and went back to my medical school for an oncology fellowship. I thought what was going to make me feel good was to be the world's most perfect something. I was going to be the world's most perfect internist and the world's best oncologist. I picked oncology because the people were so sick . . .

Finally, in a south central city is where I did my most catastrophic drinking and where almost all the bad things happened. By then, I had a private practice in internal medicine, wrote another prescription for oral narcotics for my own use, got arrested, and was put on three months' probation by the board of medical examiners. That was my first real brush with the law . . .

I was having frequent major motor seizures that were being worked up by seizure experts all over the country. Nobody asked me whether I was drinking . . .

The board of medical examiners sent me to a psychiatrist who never asked me about my drinking. I probably went drunk to every interview.

I drifted downhill within my specialty, but like a lot of physicians I preserved my job function until close to the end. I was coming home from work and drinking to pass out and my marriage was a mess, but I was still going to work. But the last 6 months of my drinking I didn't do anything but cancel appointments and not get up in the morning. Finally, enough people at this little tiny hospital where I was on staff smelled alcohol on my breath in the morning that I lost my staff privileges.

People don't realize the amount of pain that comes from chemicals. It never occurred to me that if you drink a liter of bourbon a day, you might get depressed. I thought I was just this very brilliant, lonely woman who

physicians to focus on their primary disease instead of on what sets them apart from other addicts.

"We need to know that we're addicts first and physicians second," says one physician. "Most of us don't get well until we realize that."

But the advantages of being treated in a program with at least some other addicted physicians are obvious: it helps to decrease feelings of isolation and shame ("I'm not the only one with this problem") and offers physicians peers with whom to discuss the very real problems of reentering medical practice.

dry isn't enough

ALTHOUGH FEAR AND anxiety are common first responses to a diagnosis that implies giving up what an addict most cherishes, Dr Dalton says the picture brightens.

"Their fear is that abstinence means life is essentially over," he says. "They are afraid there will never be any more fun, any more enjoyment of work, any more enjoyment of sex, any more enjoyment of anything." Instead, recovering addicts slowly learn that abstinence can be the beginning of a life richer in every aspect than before.

"I often tell patients that I wouldn't wish for them to just quit drinking," says Dr Arredondo. If they don't develop coping skills to replace the addictive behavior, "they're going to just be not drinking and miserable."

One recovering alcoholic-physician vividly remembers the early days of abstinence: "It was terrible getting through a single day without alcohol. I used to go to bed at 5 o'clock in the afternoon in order to end the day, so I didn't have to think about drinking."

There's a real difference between being "dry," and being in recovery, says Dr Arredondo. Being dry is just being abstinent and sometimes miserable.

Recovery, however, begins when addicts start to address the areas of their lives that were harmed by the addiction or that needed strengthening even before the chemical dependency. Because many long-time addicts either never learned or have lost a lot of "people" and coping skills, they must deal not only with the physical, but also the emotional and spiritual aspects of themselves.

The 12-step programs such as Alcoholics Anonymous or Narcotics

was depressed and happened to drink a little bit. I swear it never occurred to me that a liter of alcohol a day was a very significant depressant and that maybe it had some relationship to my feeling depressed all the time.

I had been thinking about suicide for a long time. After the suspension from the hospital staff, I took a scalpel to my femoral artery. My husband found me and I went to the ER, got sewn up, and put on the psych unit. I was there for about 3 weeks and it was a really ugly experience. I decided that I could at least play the game well enough to get out of the locked unit. They let me out for Thanksgiving for 24 hours. And in 24 hours I managed to write another illicit prescription, get arrested, get wildly drunk in front of my in-laws who had never really understood how sick I was, and get sent back to the psych hospital, at which point even the psychiatrist decided he had at least one good idea of what was wrong with me. He said: "I think you're alcoholic. We're going to have to get you to AA meetings."

By the time I got out of the psych hospital, I thought it might be a good idea if maybe I cut down on my drinking. I never considered quitting. I needed it too much.

So I was out of the psych hospital without a job, and I tried to keep going to AA meetings, but it was the strangest thing — I kept getting drunk. Finally one day, I decided what was really wrong with me was not my drinking but the fact that I hadn't changed my image in a long time. I have a beautiful mother and a dad who has always said that the only really important thing for women is to be perfect and beautiful. So I thought my problem was that I wasn't beautiful enough. I went and had these long, claw-like false fingernails put on. I went straight from the fingernail place at about 9 o'clock in the morning to the liquor store and bought one of those little alcoholic half-pints of Old Crow. I stood in my own kitchen in the sunshine drinking and vomiting into my kitchen sink.

Something very important happened to me with that last drinking episode: as soon as I sort of recovered from being totally drunk I wanted to kill myself again. And I finally made the emotional connection between wanting to commit suicide and drinking alcohol. I stayed drunk for a day and a half just on a tiny amount of alcohol.

So I went drunk to another AA meeting and I told them, "There's something wrong with me. I can't quit drinking." And they said, "That's right. Congratulations. Maybe you've got a chance in this program after all."

I had my last drink Jan 25, 1982, standing in my own kitchen. I never went through treatment. Instead, I sort of crawled through Alcoholics Anonymous and it saved my life.

The real miracle is that occasionally people ask me, "Are you sure you drank too much?" I tell them, "Hey, I am certain, and out of the two of us, I'm the person who needs to be sure. Don't you worry about it. I drank too much, too often, and too long." But it's nice to know that recovery proceeds in a complete enough fashion that people have a hard time imagining what you were like before.

They think surely this woman didn't sit in one bathrobe in one spot on her sofa and read one chapter of *Little Women* over and over again day after day and never take a bath. But that's what I did. I always read the chapter where Beth dies. I've gotten rid of the bathrobe and the sofa and the house, but I still have the book with my tears on the page.

Anonymous serve as training grounds for developing the skills to cope with life in a new, healthy way, say those who treat addicts.

Dr Arredondo says very few addicts ("probably less than 2%") recover without them. "Recovering docs will tell you that treatment saved their life, but that what really got it back into shape was AA," he says.

stepping into recovery

TO OUTSIDERS, THE ZEAL with which recovering addicts describe 12-step programs can be hard to take.

"My theory on AA meetings when I first went was that there was a mass religious hallucination going on," laughs one recovering alcoholic-physician. "They were all so happy and they told the most incredible stories about what had happened to them. I thought it was a fascinating psychological phenomenon, but I was totally on the outside of it."

Since that time, she has become an insider. "The reason I go to meetings is real simple: I am dead certain I will drink again if I don't."

But resistance to the regimen comes not only because of the time required (recovering addicts often attend three or more meetings per week and some go daily), but also because of the stigma attached to self-help groups of any kind.

"Please mother, I'd rather do it myself," is how one physician describes a typical reaction.

Although 12-step programs are widely recognized as the most effective treatment for addiction, one physician says they are a long way from efficient.

"I think the current stats on AA are that 20% of people who go to their first AA meeting are sober 5 years later. Now in oncology, we throw out treatments that only have a 20% response rate," she says. "Fortunately AA does other things for you — it helps with your kids, your dog, your marriage, your work life, the garden."

The real test of AA's value for this particular physician came after she adopted a 3-day-old boy who turned out to have a catastrophic medical problem.

"If I hadn't had AA, I would have been crazy," she says. "I kept thinking to myself, 'Thank God, I'm not drinking, because the only thing worse than the kind of clarity I am experiencing would be that horrible

PHR committee offers advice for students, residents, and hospitals

ALTHOUGH MEDICAL SCHOOL doesn't *cause* substance abuse, the extreme stress faced by medical students can combine with other factors to leave them vulnerable to chemical dependency.

Addiction experts interviewed by *American Medical News* earlier this year reported that a disproportionate number of medical students are children of alcoholics and, thus, at risk themselves.*

In 1986, Congress mandated that all medical schools receiving federal funds establish programs to help identify and treat addicted students.

Allan McCorkle, MD, a third-year psychiatry resident at Texas Tech University Health Sciences Center in Lubbock who is the resident representative of the TMA Physician Health and Rehabilitation Committee, has been active in encouraging Texas medical schools and residency programs to create programs.

He helped prepare TMA's "Model for student assistance programs in the medical school" and is working with the committee to develop a comparable model for residency programs. He also was instrumental in starting a student assistance program at Texas Tech.

Dr McCorkle says physicians need to confront the issue of addiction within the profession in order to maintain a rehabilitative approach rather than a punitive one. "That's the reason the PHR committees formed and that's the reason student assistance committees are forming," he says. "PHR committees basically give people a chance before they hit the board (of medical examiners). Similarly, nobody on the student assistance committee is affiliated with administration."

A recent article in *The Annals of Internal Medicine* examines the extent of abuse among physicians in residency training.† It also makes recommendations for establishing a clearly defined, organized process to address the problem. The authors say many training programs do not provide educational programs on abuse and do not have a formal system to address the problem of residents who are substance abusers. A survey conducted by the TMA PHR committee of residency programs in Texas indicated that few had formal programs.

Much information about setting up committees in various settings is available from the TMA PHR committee. In addition to the recommendations for establishing student assistance programs, the committee has guidelines for hospital medical staffs concerning physician impairment, brochures that describe the addiction process, and other information about the committee's work.

Additionally, the committee conducts regional educational programs at no cost. Two programs may be scheduled: one about alcohol and other drug use and another about intervention techniques.

To order printed materials or schedule an educational program, contact Linda Kuhn, TMA PHR Committee, 401 W 15th St, Austin, TX 78701, (800) 880-1300, ext 1342.

* Morain C. Helping tomorrow's healers. *American Medical News*. February 10, 1992:21,23.
† Aach RD, Girard DE, Humphrey H, et al. Alcohol and other substance abuse and impairment among physicians in residency training. *Ann Int Med*. 1992; 116:245–254.

confusion and sense of being lost that comes from drinking.

"I had never needed that kind of help from the program before. When you think your child is going to die, it's a whole new level of pain. If AA could get me through that, the rest of the stuff it helps with is tulips."

reentry: facing relapse

HAVING "GRADUATED" from inpatient treatment that typically ranges from 1 to 4 months, most newly sober (and hopeful) physicians still face hurdles. The "real" world of patients, partners, and hospital staff privileges can be very unforgiving. Families and friends, too, need time to adjust.

Most impaired physicians are monitored by PHR committees for a minimum of 2 years. Their "after-care" usually includes regular attendance at 12-step meetings and at a physicians' recovery group, if one is available. Random urine or blood samples are almost always used to help ensure that sobriety is continuing.

And that is no small issue: addiction is a chronic disease and the relapse rate never reaches zero.

"Relapses are part of the natural course of recovery," says Dr Arredondo.

While preventing them is a fundamental issue in addiction treatment today, they do occur, most often in the year immediately following treatment.

But that doesn't mean the addict is a bad person or that he or she isn't trying, says Dr Thomas. "In AA, they say you drink as long as you have more drinking to do. And that relapses provide you with valuable additional knowledge.

"All that a single relapse tells me about a person is that the disease is worse and that the next treatment cycle needs to be different or that the monitoring needs to be different. We need to look at what predated the relapse. In this sense it's just like any other illness.

"If you put a hypertensive on medicine and they break through, and you try another medicine and they break through and wind up in the hospital, you start going through everything with a fine-tooth comb. You try to figure out whether there's an underlying illness or whether they are not taking their medicine. Maybe something is going on at home or some kind of job stress is causing this particular person to be so difficult to control. It doesn't mean they're a bad person. It means their hypertension is bad."

Physicians who are most successful in maintaining sobriety understand the need for 12-step meetings and attend regularly, say researchers who studied chemically dependent physicians treated in Georgia (5). They also learn to communicate openly and

honestly with family members, friends, and colleagues. Additionally, they learn to set priorities that make room for exercise and leisure.

But even with all-out efforts to prevent relapse, random urine and/or blood screens are needed to ensure that those who slip are quickly helped. The screens are frequent enough, particularly early in a physician's recovery, that relapses are detected quickly, says Dr Arredondo.

And that's important in order for monitoring programs to maintain credibility with hospitals, which often struggle with whether to restore or extend staff privileges to recovering addicts.

reentry: facing prejudice

THE IRONY IS THAT SOME hospitals will ignore a physician's impairment for years, but remove his or her privileges if the physician enters a treatment program.

That baffles and infuriates both recovering addicts and those who work with and treat them.

"Recovering doctors are better doctors than they were when they weren't recovering, so why punish them now?" asks Dr Ewing, of Corpus Christi. "This shouldn't be a shame-on-you thing."

Dr Thomas agrees: "The hospital has got to be willing to see physicians through evaluation, let them go into treatment, and assure them their position on the staff will be available provided they're in appropriate monitoring."

The balancing act for hospitals, says TMA's general counsel, requires ensuring both patient safety and that impaired physicians feel safe about seeking treatment.

"The hospital will tend to be conservative," says Mr Wilcox. "Its attorney is likely to say, 'We can't really take a chance with this physician, because if a patient is harmed and we knew of the physician's history . . .'

"But, if physicians see that someone who voluntarily goes into treatment can't get his job back, they will not be willing to volunteer themselves or to report others. The risk is that you're not going to find out about these problems until you have disasters."

He says hospitals must be reasonable in allowing formerly impaired physicians to come back with careful monitoring. "Yes, there is a risk," he says. "But there's a larger risk in saying 'No, you can't come back.'"

More than one recovering physician also has had trouble finding malpractice insurance. While many companies are relatively enlightened about addiction, others rarely or never extend coverage to physicians who have been in treatment, even after years of well-documented sobriety.

Another discouraging dose of reality for physicians in recovery sometimes is dispensed by the Texas State Board of Medical Examiners. Because the board's disciplinary process is quite lengthy, some physicians who have been through treatment and whose recovery is proceeding well are put on probation because of a referral to the board separate from the one to a PHR committee. That's hard for many people to understand.

"Why spend the time and effort disciplining a doctor who has already been to treatment and is doing well?" is the question often asked.

Mr Wilcox says that while the Board of Medical Examiners has generally supported TMA's physician health and rehabilitation program as an effective way to get physicians into treatment long before the board would ever find out about them, the board is under constant pressure to sanction doctors to demonstrate its vigilance.

taking the 12th step: help others

TO THOSE PHYSICIANS who have been through the nightmare of addiction, little is more satisfying than helping others confront the disease.

"As you might imagine, the reason for my activity in the PHR committee stems from my feeling that it is life-saving," says one physician. "I went to medical school so I could hear people say, 'Thank you, Doctor. You saved my life.' And, ironically, having almost died from alcoholism, I find that I'm most likely to save a life when I talk to someone who is chemically dependent. I've acquired a skill through catastrophe."

The skill is one that all physicians can share. As John M. Talmadge, MD, Plano, a member of the TMA PHR committee, wrote so eloquently in *Texas Medicine* a couple of years ago (6):

> *We can help other physicians by having the courage to speak the truth about ourselves and our profession, by having the wisdom to intervene and offer the most advanced understanding of disabling diseases, including addiction, and by reaching out assertively to the physician in trouble. Ignorance and apathy are as much our enemies as any virus or illicit drug; society continues to treat diseases as moral problems or legislative agenda items, when medicine already knows what must be done. We*

addiction: the personal stories

I sat around angry for 5 years

I WAS THE KIND OF alcoholic whose alcohol intake advanced slowly over the years. Early on I would not drink when I was on call. Later, I would have a couple of drinks on call. As time went on, instead of being on call every other night, every other weekend, I was on call every fourth night, every fourth weekend, every fourth holiday, so that left me three quarters of the time to drink.

It was 10 years before I quit . . .

I didn't go to AA, I didn't go to anybody . . . I just quit. I didn't have any trouble quitting, but I sat around angry for 5 years. Finally, the person who originally steered me away from AA, said maybe that is the place for you.

I walked into a meeting and felt like I was home. There was a tremendous spiritual feeling in that room.

must have the stamina and, again, the simple courage to get the job done.

Together, if we save a single doctor's life, we have touched the lives of a thousand others.

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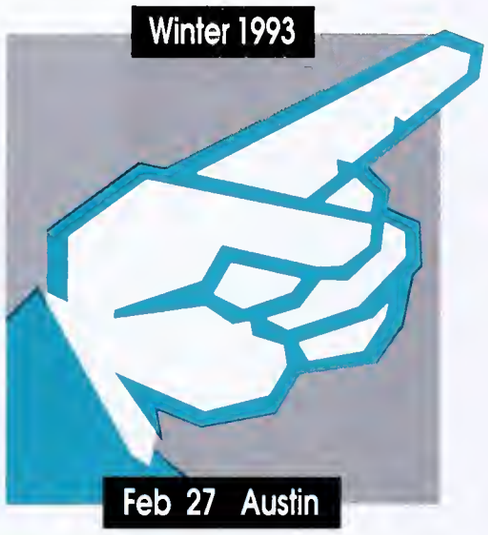
Texas Medical Association

Leadership Conference

Advocacy: A Caring Commitment



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Medical Economics

Physicians vent confusion, frustration over CLIA regulations

THERE IS LITTLE DOUBT that 1992 has been the year of government regulations for physicians. It saw the beginning of Medicare's Resource-Based Relative Value Scale (RBRVS) payment system, new Occupational Health and Safety Administration (OSHA) regulations for bloodborne pathogens, and the Americans with Disabilities Act (ADA), among others.

Each new set of rules meant time, expense, and hassle for physicians — time not spent on patient care. But if the number of phone calls and requests for information received by TMA is any indication, the Clinical Laboratory Improvement Amendments of 1988 (CLIA) were the most vexing to Texas physicians.

TMA's action plan to assist physicians with CLIA regulations was put in place earlier this year, but staff members say the volume of requests for assistance was one of the largest they have ever had in dealing with a new set of government regulations.

CLIA was designed to register, inspect, and monitor medical laboratories to protect the public from inaccurate test results, but in practice, the program has proven to be a bureaucratic boondoggle.

"CLIA is pure cost without benefit," said TMA President William Gamel, MD. "But so long as CLIA remains law, TMA will provide the help our members need in order to comply."

Since the rules were put in place in February, TMA's department of health-care financing has fielded more then 1,500 requests for assistance in registering physician-operated labs. Physicians, confused over whether their labs performed waived, moderate complexity, or high complexity tests, sought assistance in filling out a series of forms required by the federal government to comply with CLIA.

"CLIA has one of the most complex sets of regulations physicians have ever had to deal with," says Donna Kinney, TMA's CLIA program specialist. "The frustrating part for many doctors is that it seems to be just an exercise in applying the rules without thought to any real benefit to health care from the process."

Indeed, even the Health Care Financing Administration, which formulated the regulations, had major doubts about the need for the program. In the February 28, 1992, edition of the *Federal Register* (p 7121), HCFA reports:

> *Assigning an economic value to CLIA's attempt to protect the public health through laboratory regulation is problematic, at best. We broadly searched available literature for cost-benefit, cost-effectiveness, or other potentially useful studies of laboratory programs. There is little scholarship and research on the subject. . . . Moreover, there exists no irrefutable evidence demonstrating that the performance of clinical laboratories, or public health status, will be tangibly improved under regulation.*

In light of physicians' problems in getting sufficient information from HCFA about the program, TMA staff devised a program to assist physicians in complying with the regulations and keeping up with current information about the program.

In response to CLIA, TMA has:

- Conducted a series of CLIA Compliance Workshops around

Mark Richardson, *associate editor, writes and edits the Medical Economics and Science and Education sections of* Texas Medicine.

LETTER MAY HELP PATIENTS UNDERSTAND CLIA PROBLEMS

MANY PHYSICIANS HAVE NOTED that CLIA regulations are causing a disruption in their office lab routine and are causing delays and inconvenience for many of their patients. Below is the suggested text of a letter from physicians to their patients explaining the problems caused by CLIA and encouraging patients to contact their elected representatives about the problems.

Physicians may use the text provided here or may alter the letter to fit their needs.

Dear Patient,

On September 1, 1992, newly imposed federal regulations reduced my ability to serve my patients. These regulations have the effect of limiting the laboratory tests that I can provide in my office and increasing the costs for those that I do perform. This may mean that you will have to make more visits to a separate independent lab, I may experience some delay in getting the information that I need to make a proper diagnosis, and your expenses for testing may increase. I am very sorry for the inconvenience to you.

If you are unhappy about federal regulations that increase the cost of health care and decrease your access to care, write your Congressional representatives at the addresses listed below and explain your views.

The Honorable _____
United States House of Representatives
Washington, DC 20515

The Honorable Lloyd Bentsen
or, The Honorable Phil Gramm
The United States Senate
Washington, DC 20510

You may wish to fill in the name of the US representative from your congressional district.

the state, held during August and September of this year, to assist physicians with office labs in getting registered and preparing for lab inspections next year.

- Published several informational articles on CLIA in *Texas Medicine* magazine, *Action* newsletter, and several other TMA publications during the year.
- Published the "CLIA Compliance Manual," a self-learning guide and audiotape program containing a handbook of CLIA regulations and an audiotape of the CLIA workshop. (See ordering information below.)
- Assisted more than 1,500 physicians who contacted TMA regarding CLIA registration and provided copies of appropriate forms.
- Began the "CLIA Information Service," a program that will, through a regular newsletter, keep subscribing physicians informed of new developments in the CLIA program. The service is automatically provided to physicians who attended the CLIA Compliance Workshops or who order the CLIA Compliance Manual.
- Adopted a strong advocacy role on behalf of Texas physicians, along with the AMA and other medical societies, in presenting physicians' concerns about problems with the CLIA program directly to HCFA and to legislators on Capitol Hill. Such efforts prompted HCFA to expand its program to provide CLIA information to physicians and convinced the agency to drop plans for unannounced lab inspections and to grant a 90-day extension of the deadline for CLIA compliance for Medicare claims.

For question about CLIA, contact Ms Kinney at (800) 880-1300 or (512) 370-1422. To order the CLIA Compliance Manual, contact the TMA practice management services office at (800) 880-1300 or (512) 370-1411. The manual is $89 for TMA members and $165 for nonmembers.

Medicare Physician Advisory Committee sets December meeting

THE NEWLY APPOINTED Texas Medicare Physician Advisory Committee (MPAC) will hold its first meeting December 16 in Dallas, according to W.A. Godfrey, Jr, MD, medical director of Blue Cross and Blue Shield of Texas.

Dr Godfrey, who will serve as cochairman of the group, says he plans for the committee to get right to work.

"This will be more than just an organizational meeting," he said. "We will have several draft medical review policies to consider. We will also elect another cochair for the group and hear a presentation from HCFA on the status of CLIA implementation. We have a lot of work to do."

The MPAC was established under HCFA requirements adopted as a result of the Health and Human Services Department's Committee on Medicare Physician Relationships, also known as the Gary Committee. The 43-member Texas MPAC will meet at least quarterly, and will:

- Provide a formal mechanism for physician participation in the development of medical review policy.
- Identify areas to improve administration of Medicare and to resolve problems.
- Allow information exchange between physicians and Medicare.

The members are drawn from various physician organizations, specialty societies, allied health organizations, and other groups. A representative will also represent the interests of Medicare beneficiaries.

TMA has appointed President-elect Robert M. Tenery, MD, Dallas, as its representative. Robert L. Donald, MD, Houston, vice-chairman of the Council on Socioeconomics, is the alternate member.

Other members and their affiliations are:

SPECIALTY SOCIETIES: William Lumry, MD, Texas Allergy Society; James T. Pyron, MD, Texas Society of Anesthesiologists; James Atkins, MD, American College of Cardiology; James D. Maberry, MD, Texas Dermatological Society; R. Lynn Rea, MD, American College of Emergency Physicians; Jimmy Randles, MD, Texas Academy of Family Physicians; Delbert L. Chumley, MD, American College of Gastroenterology; John Preskitt, MD, American College of Surgeons; David Gordon, MD, American Society of Hematology; Joseph S. Bailes, MD, Texas Society of Internal Medicine; Lewis J. Hellerstein, MD, Texas Society of Medical Oncology; Alan R. Hull, MD, Renal Physicians of Texas; Phillip Leonard, MD, Texas Neurological Society; Richard H. Jackson, MD, Texas Association of Neurological Surgeons; Donald N. Podoloff, MD, Texas Association of Physicians in Nuclear Medicine; John Haley, MD, Texas Ophthalmology Society; Dudley Jones, MD, Texas Society of Pathologists; Larry Patton, MD, Texas Pediatric Society; G. Patrick Clagett, MD, Society for Vascular Surgery; Milton D. Thomas, MD, Texas Physical Medicine and Rehabilitation Society; Hamlet T. Newsome, MD, Texas Society of Plastic Surgeons; Edward W. Tuthill, MD, Texas Society of Psychiatric Physicians; John D. Hughes, MD, Pulmonary Medicine; Gary R. Leach, MD, Radiation Oncology; Wm. Bruce Lowry, MD, Texas Radiological Society; Den E. Cheatum, MD, American College of Rheumatology.

Other organizations: Joseph H. Jones III, DC, Texas Chiropractic Association; Kim Castleberry, OD, Texas Optometric Association; Donald F. Vedral, DO, PhD, Texas Osteopathic Medical Association; Paul Kinberg, DPM, Texas Podiatric Medical Association; Allen M. Fain, MD, Texas Medical Foundation (PRO); Luther Jack Bolton, DDS, Texas Dental Association; M. Derrick Boldt, MD, Texas Hospital Association; Robert K. Pendergrass, MD, Texas Medicaid NHIC; Isabel V. Hoverman, MD, Liaison to National Committee; Earl Landis, Silver-Haired Legislature, Beneficiary Representative; Robert A. Felix, FACMGA, Medical Administrators of Texas.

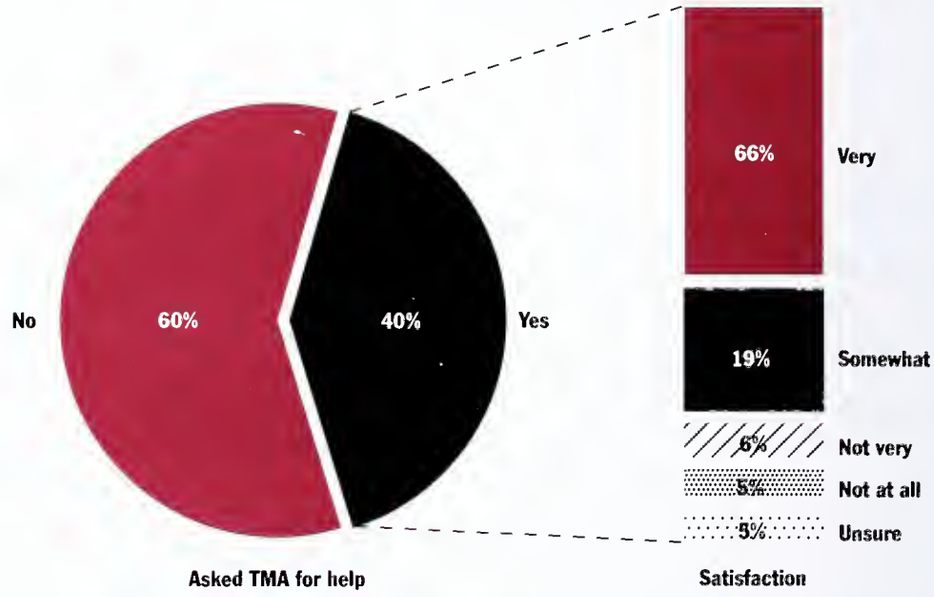
TMA takes biennial self-portrait

EVERY 2 YEARS, THE Texas Medical Association takes a snapshot of itself. In its biennial Survey of Physicians for 1992, a random sample of Texas doctors — both TMA members and nonmembers — were asked for their opinions on a wide variety of topics and issues surrounding medicine. Their answers reveal quite a bit about the state of medicine in Texas today and also serve as a guide for TMA staff members in conducting programs and implementing TMA policies.

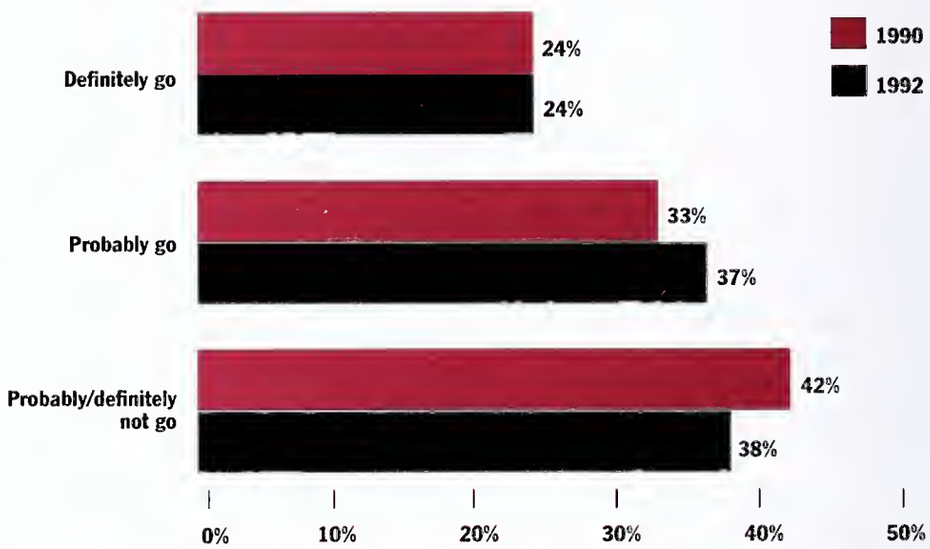
"I think what these numbers show is a significant change in physicians' attitudes on the economics, the politics, the business, and the practice of medicine," said Louis Goodman, PhD, TMA's director of medical economics. "The political debate during this election has pushed health care into the public spotlight."

Physicians were asked for their opinions on topics such as government regulations, public health problems, legislative issues, reimbursement issues, practice management issues, and TMA communication programs. The survey, conducted by MVA Research of Houston, interviewed 600 physicians during September and October of 1992 by telephone and has a margin of error of ±5%.

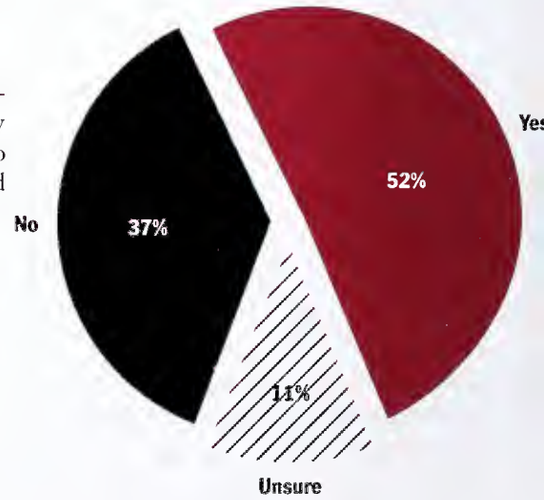
Satisfied with help from TMA?
Of the 40% of physicians surveyed who had contacted TMA for assistance, 85% were satisfied with the assistance they received.



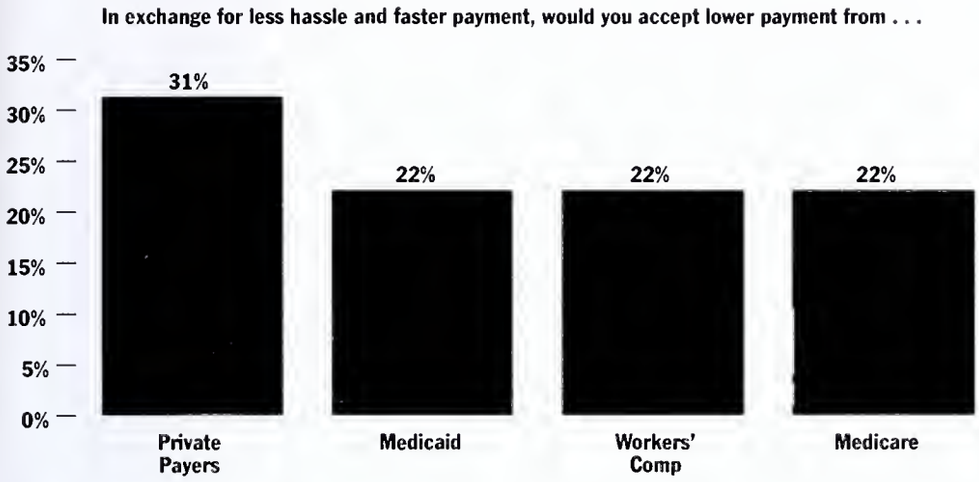
Would you attend medical school again?
Texas physicians appeared slightly happier with their choice of profession in 1992 than in 1990. More physicians said they would probably go to medical school again, while the number saying they would not showed a corresponding decrease.



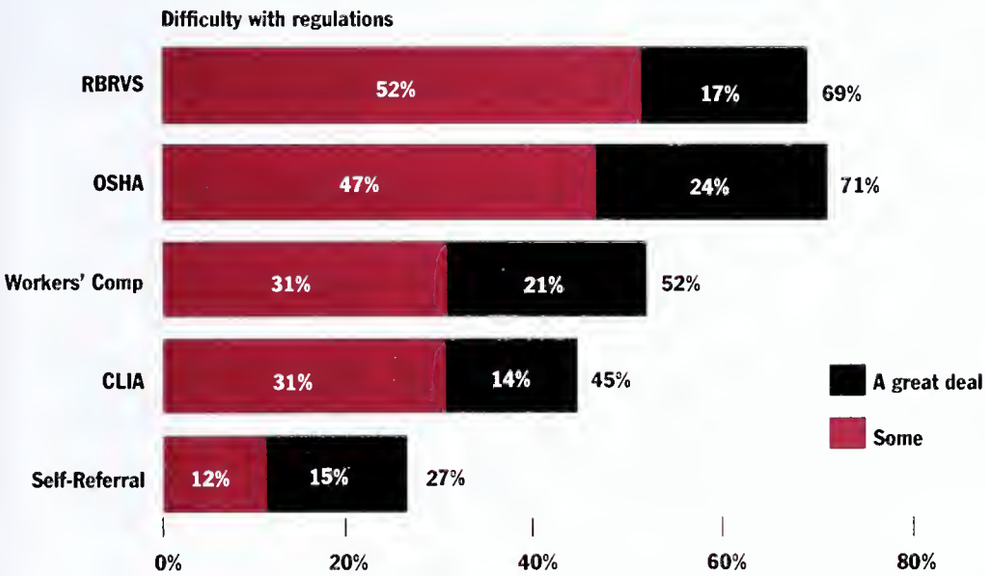
Would you recommend medicine as a career?
Slightly more than half of the physicians surveyed said, based on their experience, they would recommend a career in medicine to someone else. However, more than one third (37%) said they would not.



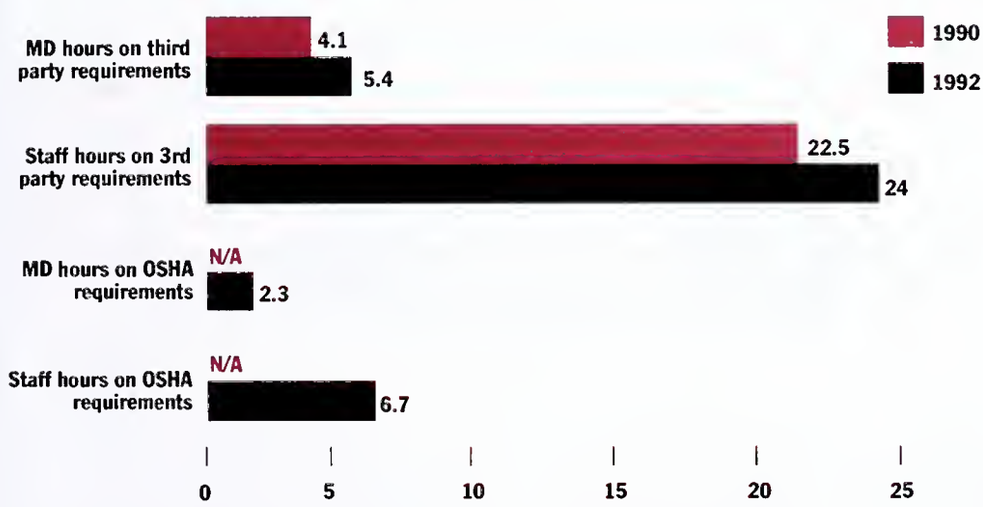
Less money for less hassle?
Almost one third of those surveyed said they would take a lower rate of reimbursement from private payers if they could get that money more quickly with less hassle. Far fewer would take the same deal from government programs, which already pay at a lower rate.



Are you having difficulty with regulations?
A significant number of physicians say they are having difficulty coping with the regulations of government programs such as RBRVS, OSHA, Workers' Compensation, and CLIA.



How much time do you spend on hassles?
Physicians showed an increase in the number of hours they and their staff members spend dealing with third-party payors and OSHA requirements.



TMF issues advisories for CHAMPUS claims

THE TEXAS MEDICAL Foundation (TMF), which handles medical peer review for the south central region (including Texas) for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), issued two reminders recently for physicians who file claims under the program:

- In issuing a recent set of instructions and billing codes for procedures needing preauthorization (*Texas Medicine*, October 1992, p 49), TMF inadvertently left out a series of codes. TMF asks participating physicians to add the following ICD-9-CM codes to the list published in October:

Biliary tract operations
51.22 Total cholecystectomy
51.23 Laparoscopic cholecystectomy

C-section/removal of fetus
74.0 Classical cesarean section
74.1 Low cervical cesarean section
74.2 Extraperitoneal cesarean section
74.4 Cesarean section of other specified type
74.99 Other cesarean section of unspecified type

Other uterine incision or excision
68.4 Total abdominal hysterectomy
68.5 Vaginal hysterectomy

- CHAMPUS claims processors will no longer accept obsolete versions of the HCFA 1500/

CHAMPUS 501 claim form from providers after December 31, 1992. Versions of HCFA 1500 forms dated "(12-90)" in the lower right hand corner will be the only form accepted after January 1, 1993, regardless of when the services listed on the form were provided.

Claims received after the first of the year on the old form will be returned with a letter stating that they must be resubmitted on an appropriate form. The new HCFA 1500 form *does not* contain the "CHAMPUS 501" designation.

The new form may be ordered from most printing vendors or you may obtain them directly from: Superintendent of Documents, US Government Printing Office, Washington, DC 20402, (202) 783-3238, or American Medical Association, PO Box 109050, Chicago, Ill 60610, (800) 621-8335. ★

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Some People Commit Child Abuse Before Their Child Is Even Born.

According to the surgeon general, smoking by a pregnant woman may result in a child's premature birth, low birth weight and fetal injury. If that's not child abuse, then what is?

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GENERAL INTERNISTS In Central Texas

The Scott & White Clinic, a multispecialty clinic of 350 physicians, has several opportunities for general internists.

One internist is needed to join the growing 8-physician staff in its Taylor facility. The Taylor community has a population of 11,000 and is located north of Austin.

An internist is needed for the clinic in College Station. This multispecialty clinic has 30 staff members, including 4 internists. Bryan/College Station is the home of Texas A&M University and has a 100,000 population.

The Gatesville Clinic also needs an internist to join its 10 physician staff. Gatesville has a population of 7,000.

Scott & White offers an excellent benefit and salary package. Excellent educational opportunities. Medical school affiliation available.

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S&W SCOTT & WHITE

Public Health

Toll-free number provides access to Alzheimer's information

THE TEXAS MEDICAL Association has joined forces with the Texas Department of Health Alzheimer's Disease Program to provide resources on the disease tagged the "thief of the mind."

To publicize the program's toll-free information line, (800) 242-3399, a resource card was mailed in November to physicians specializing in general practice, geriatrics, family practice, psychiatry, internal medicine, and neurology.

"There is a need in the state for a clearinghouse of resources for patients and their families," says Catherine R. Edwards, PhD, director of TMA's division of public health and scientific affairs. "TDH is fulfilling that need and TMA will be cooperating."

Although the "800" service has been in existence since February 1991, there hasn't been a campaign to publicize the number.

"We want to publicize the service more because there are individuals who don't realize resources are available to help them and their families cope with the illness," says Veronda Durden, TDH program director for Alzheimer's disease.

Physicians are encouraged to use the number and also direct their patients to call the health department service for educational material on Alzheimer's disease.

The toll-free number is answered daily from 8 am to 5 pm. Callers will receive an informational packet that contains booklets on national and state programs along with listings of support groups.

Laura J. Albrecht, *associate editor, writes and edits the Law and Public Health sections of* Texas Medicine.

Ophthalmologists participating in TDH eye disease program

INDIGENT TEXANS WITH diabetes are no longer going without vital screening for eye disease due to a state program that enlists the skills and goodwill of Texas ophthalmologists.

Created in 1989, the Diabetic Eye Disease Program is funded by the Texas Diabetes Council. The screening program, which has provided exams to 4,078 patients, is part of the Texas Diabetes Control Project that began in 1986 under a grant from the Centers for Disease Control.

"Patients who are out of the mainstream of health care are benefitting from the program," says Austin ophthalmologist Brian B. Berger, MD. The program stresses preventive care and gives physicians the opportunity to explain to patients with diabetes the importance of eye examinations, he says.

The project relies on public health department nurses to identify patients who are at high risk for diabetic eye disease. The patient is then referred for an eye examination by one of about 175 ophthalmologists who have volunteered their services. The Texas Commission for the Blind provides financial assistance after eligibility requirements are met to patients who need treatment.

Cases of cataracts, retinopathy, maculopathy, and glaucoma have been diagnosed in 2,039 patients.

"It takes everyone working together to impact a problem of this magnitude," says Charlene Laramey, RN, CSW, director of the Texas Department of Health Chronic Disease Prevention Program. "This program is a partnership between the private and public section and it is working very well."

In many cases the private sector is providing treatment such as laser therapy, free of charge. This results in a cost-effective program, says Ms Laramey.

Ophthalmologists interested in participating in the TDH program may contact Pete Hoffman or Phyllis Washington at (512) 458-7534.

Diabetes in Texas

- More than 850,000 Texas residents are estimated to have diabetes. Only half have been diagnosed.
- Diabetes contributed to the deaths of more than 7,212 residents in 1987.
- Each year diabetes-related complications include blindness, lower-extremity amputations, end-stage renal disease, hospitalizations, and long-term reduction in activity.
- In 1987, the direct (medical care) and indirect (lost productivity) cost of diabetes was about $1.2 billion.

Diabetes in the United States

- About 14 million Americans have diabetes, but only about 7 million have been diagnosed.
- About 677,000 new cases of diabetes are identified each year.
- In 1988, diabetes contributed to more than 157,000 deaths and ranked 7th among the leading causes of death in the United States.
- An estimated $20.4 billion in direct medical costs and costs resulting from lost productivity was attributed to diabetes.

Source: Texas Department of Health

AGENDA ON AIDS

CDC ranks AIDS 9th among causes of death

The US Centers for Disease Control placed AIDS as the 9th leading cause of death in the United States during 1991. The disease was 11th on the list in 1990.

Survey: television programs educate adults about AIDS

Television was the most common education source for AIDS education for adults according to a 1991 AIDS Knowledge and Attitudes Survey. Seventy-two percent of adults responding to the National Center for Health Statistics' survey selected television, followed by newspapers (43%) and magazines (39%). Other findings from the survey included:

- Most of those who had never been tested for HIV apart from blood donation stated this was because they were not at risk of acquiring HIV infection.
- Half of all adults had heard of azidothymidine (AZT).
- Seventy-six percent of adults believed condoms were somewhat effective in preventing sexual transmission of HIV.
- Only 17% of respondents knew that natural membrane condoms and latex condoms were not equal in preventing transmission of HIV.
- Twenty-six percent of respondents knew that oil-based lubricants could damage condoms.

COMMENTARY

Physicians can help victims of violence during examinations

Diana L. Fite, MD
Chair, Committee on Sexual Assault and Domestic Violence Prevention, Harris County Medical Society

Patient Jane W had been seen frequently by her family doctor and gynecologist for pelvic pain. She even requested a hysterectomy to relieve the pain. A previous diagnostic laparoscopy, however, had failed to reveal any pathology, so her gynecologist declined to perform the operation. Jane refused to see a psychiatrist because her husband told her the problem wasn't "in her head." During one office visit the gynecologist asked her why she had a linear series of bruises on both inner thighs (an obvious pattern of pressure from fingers). Mrs W admitted that she had been hurt even more severely than usual by her husband prior to intercourse while trying to resist his advances. Upon further discussion, she revealed that he had always beaten her prior to intercourse. Because this was the usual pattern, she had not consciously realized this situation had resulted in pelvic pain.

THE PRECEDING CASE illustrates the importance of discussing family violence early in a physician-patient relationship. Physicians are now realizing that physical and sexual violence against women, men, children, and the elderly by family members or other intimate relationships is a public health problem that has reached epidemic proportions. One quarter of the women in the United States will be abused by a current or former partner at some time during their lives. This means most physicians are seeing abused patients every single day in their practices.

Estimates are that 52% of female murder victims are killed by a current or former partner. Child homicide is now among the five leading causes of death in childhood, with the majority of infant victims killed by parents, relatives, and older children.

Through awareness and education, physicians may be able to put a kink in the chain of violence that usually starts insidiously, progresses in severity, escalates in frequency, and sometimes results in death.

We may be able to break the cycle of violence by addressing the problems during examinations. By now many of us have read the American Medical Association's recommendations for routinely questioning patients about domestic violence. However, it is still difficult for most of us to ask these questions. Not only is it time-consuming, but primarily we are afraid of insulting our patients.

We can get the message across without endangering the well-being of our patients. Consider taking the following steps to let your patients know you are aware of the plight of victims of domestic violence in Texas.

- Place posters concerning family violence in your office.
- Wear lapel buttons, such as the one — *Family Violence Hurts Everyone* — distributed by the Harris County Medical Association, on your coat. This lets patients know you are aware of family violence and are willing to help.
- Ask questions relating to family violence when conducting medical histories. You can ask patients if they know of someone who may be abused and if they would like to have a phone number to give to that person for help.

Acts of violence during pregnancy

A survey funded by the Centers for Disease Control reveals that one in six women are physically abused sometime during pregnancy. Interviews with 691 pregnant women were conducted at Houston and Baltimore public health clinics. The study revealed that Anglo women suffered more frequent and severe incidences of abuse than black or Hispanic females. Findings from the study were published in the June 17, 1992, issue of *Journal of the American Medical Association.*

Many times the batterer will bring the victim to the emergency department for treatment. This can make it difficult to ask questions since he will not want to leave his victim alone for fear of being reported to authorities.

- Distribute pamphlets with information on battered women's centers and emergency phone numbers. Many victims fear they will be abused more if their assailant learns they are seeking help. Helpline phone numbers can be distributed on small cards (placed in the restroom), which can then be concealed in a patient's purse, shoe, or sock.

The victim's self-esteem will be improved each time she is told she deserves to feel safe in her own home and that help is available to change that situation. And it will increase the chances the victim will eventually escape the acts of violence.

Start the Healing Now campaign urges physician involvement

THE TASK NOW begins for the Texas Medical Association to "restore the health, well-being, and hope to hundreds of thousands of Texans who are slapped, beaten, punched, shoved, stabbed, and raped by members of their own family." TMA President William G. Gamel, MD, announced the association's Family Violence Prevention Program Initiative during a news conference held October 1, 1992, at the Texas State Capitol. "Through awareness, information, and the proper tools, we believe physicians can better identify victims of family violence," said Dr Gamel. "We have a special responsibility to do so." Appearing with Dr Gamel were Debby Tucker, executive director of the Texas Council on Family Violence, and Camille Miller, interim executive director of the Texas Department of Protective and Regulatory Services. "We are now legitimizing the issue of family violence," said Ms Tucker. Ms Miller added, "Our individual agencies, state officials, church and community leaders have talked against violence but now is the time for the community to accept responsibility and take action." Information on the campaign is available by calling (800) 880-1300, ext 1390 or (512) 370-1390. ★

Debby Tucker, executive director of the Texas Council on Family Violence, and TMA President William G. Gamel, MD, urged physician involvement in the TMA Family Violence Prevention Program during a press conference in October.

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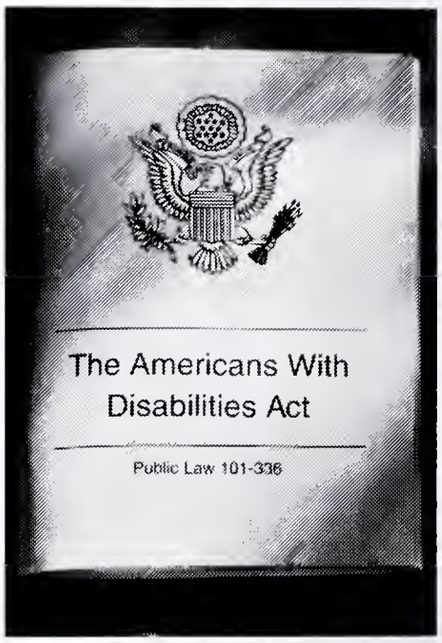

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Current Medical Specialty(ies)

Former Medical Specialty(ies) (for past 10 years)

List surgical procedures routinely performed

State(s) where currently licensed

States where formerly licensed (for past 10 years)

Amount of Professional Liability Insurance now carried
$

Is the doctor involved with delivery of babies? ☐ YES ☐ NO

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TexasMedical Association

PHYSICIANS CARING FOR TEXANS

Hepatitis B screening in pregnancy: practical aspects

VIRGINIA A. MOYER, MD, MPH

Hepatitis B may be acquired at birth from a mother who is a chronic carrier and may result in debilitating liver disease later in life. Screening of pregnant women and preventive measures have been shown to be clinically effective and at least marginally cost-effective. The Centers for Disease Control recommends universal screening of pregnant women. Cost-effectiveness has been evaluated using estimated costs and assuming patient compliance. The practical aspects of screening a high-risk population are described in the context of a single program, with discussion of excess costs and problems with implementation.

HEPATITIS B IS USUALLY an acute, self-limited disease, but some individuals become chronically infected. Because the rate of infection and chronic disease is high in infants exposed at birth by mothers who are chronic carriers, universal prenatal screening has been recommended by the Immunization Practices Advisory Committee (1). Several analyses of the expected cost-benefit ratio of such programs have been published (2–4), but little has been written on the actual costs or benefits of such programs after implementation.

In March 1990, Lyndon B. Johnson (LBJ) General Hospital, a public hospital in Houston, Tex, began screening all pregnant women for hepatitis B at the time of delivery. This action was taken in part because of recommendations from the Centers for Disease Control (CDC) and because the almost exclusively indigent maternal population of the hospital was thought to be at high risk for hepatitis B infection (5). The purpose of this study was to evaluate this perinatal screening program for hepatitis B.

SCREENING FOR HEPATITIS B

Principles of screening for disease were published by the World Health Organization in 1968. The criteria, summarized in Table 1, have been widely used to evaluate screening programs (6). In this section, the disease and the screening test are described and how they meet screening criteria is discussed.

Hepatitis B is an acute infection, most common among young adults, with a case-fatality rate for reported cases of 1.4%. Most infections in adults are self-limited and resolve within 6 months, but in about 6% to 10% of adults and about 24% to 50% of children, the infection fails to resolve and they become chronically infected. Of infants who are infected at birth, 90% become carriers and nearly all eventually have some manifestation of chronic disease. It is estimated that 25% or more of children infected at birth will die eventually of cirrhosis or hepatocellular carcinoma (7). Hepatitis B is an extremely important cause of morbidity and mortality worldwide, with up to 15% of the population in Asia and Africa being chronically infected. In the United States, about 300,000 new cases of hepatitis B occur each year, 10,000 require hospitalization, and 250 die of fulminant hepatitis. Each year, of the approximately one million chronic carriers in the United States, 4,000 people die of cirrhosis and 800 die of hepatocellular carcinoma (1). At the national prevalence rate of about 0.3%, we may expect 100,000 people in metropolitan Houston to be carriers. In short, the

Table 1. Criteria for evaluating screening programs.

1. The condition sought by screening should be an important health problem. Either the disease should be widespread or its effects should be devastating for screening to be justified.
2. The disease should have an acceptable form of treatment that is more effective when administered before symptoms appear or early in the course of the disease.
3. The properties of the test (accuracy, reliability, sensitivity, and specificity) should be known and acceptable.
4. The medical care system should be able to handle patients who are identified and to provide adequate treatment, and the treatment should be acceptable to patients.
5. The cost of screening should be economically balanced with the cost of medical care as a whole.

Presented in part at the 32nd Annual Meeting of the Ambulatory Pediatric Association, Baltimore, Md, May 1992. Send reprint requests to Dr Moyer, Assistant Professor, Department of Pediatrics, UT Health Science Center at Houston, 6431 Fannin, Houston, TX 77030.

burden of this disease, both worldwide and locally, is great.

Vertical transmission of hepatitis B from carrier mother to newborn can be prevented more than 90% of the time by administering hepatitis B immune globulin (HBIG) and vaccinating the susceptible infant (3). Current thought is that HBIG should be given within 12 hours of birth to provide the infant with passive immunity before infection takes place. Hepatitis B vaccine is given as soon as possible after birth, again at 1 month, and at 6 months. While both HBIG and vaccine are recommended, treatment with only one of these modalities is successful in preventing transmission about 75% of the time (3). Note that recommendations regarding prevention of hepatitis B in the newborn are changing rapidly. The LBJ screening program followed 1990 CDC recommendations (1) for immediate HBIG and vaccine as soon as possible. Currently, CDC recommends vaccine within 12 hours as well (8).

Patients at risk (infants of carrier mothers) are detected by screening for the presence of hepatitis B surface antigen (HBsAg) during pregnancy. The HBsAg is a complex antigen found on the surface of the virus, the presence of which in serum is considered to be indicative of active infection. The test in common use is an enzyme-linked immunosorbent assay, which is extremely sensitive (ie, nearly all persons who are infected will have a positive test) and specific (ie, nearly all healthy persons will have a negative test) (6). A single test performed at some time during pregnancy has been recommended by the CDC (1). Occasionally, a pregnant woman with self-limited disease rather than the carrier state will be detected by a single test.

Recommended follow-up for infants of mothers who are HBsAg positive requires clinic visits at 1 month and at 6 months and the ability to provide follow-up testing of the infant to determine whether he or she is a carrier or is immune. This entails one more visit, two more vaccines, and more blood work than is ordinarily included in infant health supervision. Considering the relatively small number of patients involved, this is not a large additional burden on the medical care system.

Whether screening pregnant women for hepatitis B is cost-effective has been controversial. The Immunization Practices Advisory Committee altered its recommendation from screening only persons with known risk factors (such as intravenous drug abuse or multiple sexual partners) to universal screening in 1988, and the CDC followed in 1990 (1). In 1989, Koretz argued that the cost of universal screening was too high, while Arevalo and Washington in 1988 argued that screening is cost-effective (9,2). These two analyses differed in that the first assumed a much lower transmission rate (10% vs 40%) and did not take indirect costs into account. Neither considered the possible benefits of preventing transmission other than vertical transmission at birth. Using the latter estimates, screening is cost-effective at a prevalence of 0.06% or higher. If lower transmission rates are assumed, then screening becomes cost-effective at a prevalence of 0.7%. Finally, if only direct costs are considered, screening is expected to be cost-effective at about 1% prevalence in the screened population.

In summary, hepatitis B in the pregnant woman meets most of the accepted criteria for a screening program. The burden of disease is great, a simple intervention can prevent disease transmission, and the test is reasonably accurate. The cost-effectiveness of screening is sensitive to fairly small changes in prevalence and rate of transmission as well as to which costs are included in the analysis.

SCREENING IN PRACTICE

Located in the northeast quadrant of Houston and Harris County, the LBJ General Hospital is one of two general hospitals operated by the Harris County Hospital District. This hospital and four associated community health centers serve the indigent and medically needy population located in the northern half of Harris County. Between 10% and 15% of babies born in Harris County are delivered at LBJ.

In an effort to comply with 1990 CDC recommendations, all pregnant women admitted to the labor and delivery area at LBJ General Hospital from July 1, 1990, to June 30, 1991, were tested for HBsAg. Infants of HBsAg-positive mothers were given hepatitis B immune globulin within 12 hours of birth and hepatitis B vaccine before discharge, usually within 36 hours of birth. Infants of mothers whose HBsAg status was unknown at 12 hours after birth were given immune globulin at that time as well. Follow-up was conducted through the infectious disease clinic as well as through the comprehensive community health centers associated with the hospital, in a manner similar to follow-up of other complicated newborns.

In January 1991, the City of Houston initiated a hepatitis B screening program, in which all women obtaining prenatal care were tested for HBsAg at the first prenatal visit (usually in the second or third trimester). Prenatal testing was also

performed routinely at the Harris County health clinics and at the high-risk obstetrical clinics at LBJ General Hospital.

The test used at LBJ is a qualitative immunoenzyme assay with positivity determined by spectrophotometric measurement of bound antibody conjugate (ORTHO Antibody to HBsAg ELISA Test System 2, Ortho Diagnostic Systems Inc, Raritan, NJ 08869). The test has two steps and has several points at which technique and equipment may cause a negative specimen to appear falsely positive. All initially positive tests are repeated on the same specimen and reported as positive only if the repeat is also positive. Initial false-positive tests occur frequently, usually several at a time, indicating problems in processing rather than problems related to the specimen. Confirmatory neutralization tests are not obtained in this laboratory, but all positives are tested for antibody to the hepatitis B core antigen and antibody to the hepatitis B surface antigen.

Between July 1, 1990, and June 30, 1991, there were 7,431 infants delivered at LBJ General Hospital. Twenty-six mothers tested positive at the time of delivery, giving a carrier rate of 0.35%. An additional 2 mothers were known to have tested positive during pregnancy but were negative at the time of delivery. Twenty-seven infants were born to 26 mothers who were identified as HBsAg positive at delivery. One infant did not receive HBIG until 48 hours after birth, and 1 infant did not receive the first dose of vaccine. All of the rest received HBIG and vaccine in a timely manner.

Nine of 27 (33%) infants vaccinated at birth are known to have received the second (1-month) dose of vaccine, and 2 of 16 (12.5%) infants eligible for three doses have received all three. Six of 27 (22%) infants are known to be up-to-date for age with this vaccine series. Two infants whose series were incomplete are known to have left the Houston area.

DISCUSSION

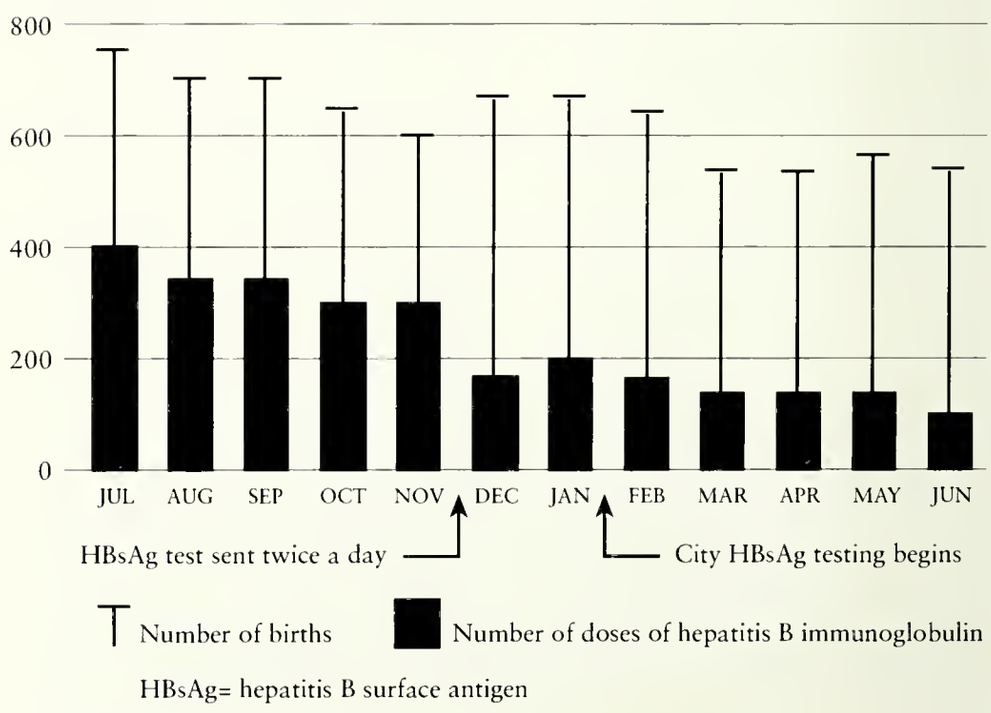
Having determined that screening for a disease is justified in principle, we must evaluate the actual outcome of the screening program. This is particularly true when the program is near the balance point for cost-effectiveness; in such a case, any unnecessary costs would tip the balance away from cost-effectiveness. Both clinical effectiveness and costs should be evaluated.

The screening program used at LBJ has been successful in testing all women who deliver at the hospital. The carrier rate for this 1-year period was 0.35%, less than half the rate for a similar population in New Orleans (4).

Performing the test at the time of delivery meant that results were often not available before the infant was 12 hours old, and many infants were given HBIG unnecessarily. While no adverse effects have been associated with HBIG in our setting, some parental concern about these injections has been raised, both from a clinical and from a cost standpoint. Midway through the year, the laboratory added a second daily run for HBsAg to decrease the number of unnecessary doses of HBIG being given. As can be seen in Fig 1, the number of doses of HBIG given to infants of mothers who were HBsAg negative fell dramatically when the laboratory began running the test twice a day.

Providing HBIG and vaccine shortly after delivery for infants of positive mothers has not been a problem. Follow-up of infants identified at birth has been extremely poor, however. In spite of efforts to educate parents about the impor-

Fig 1. Doses of hepatitis B immunoglobulin administered.



tance of completing the vaccine series, sending infants home with established appointments for follow-up, and efforts to reach patients who fail to keep appointments, less than one quarter of infants are up-to-date for age with the vaccine series. Between administration of HBIG and partial completion of the vaccine series, some protection for these infants has been provided. The medical care system has the capacity to handle the additional visits and vaccine but has not adequately addressed the issue of patient education and compliance. Follow-up in indigent populations is often extremely poor, particularly when the "illness" is asymptomatic. Funding that has allowed the City of Houston Department of Health and Human Services to provide prenatal testing has also allowed for a public health nurse to be hired to ensure follow-up for these infants. It is not yet clear whether this will improve the effectiveness of the program, although early anecdotal results are encouraging. However, the need for such personnel will add to the cost of the screening program.

The direct costs of the screening program include the cost of the test, the cost of confirmatory tests, and the cost of prevention in the infant. The charge for the HBsAg test (assumed to reflect its cost) is $30.50. The cost of confirmatory testing is an additional $68.50. HBIG and vaccine each cost about $16.00 per dose plus $10.00 per dose for cost of administration. Estimated total cost for the year should be about $230,000.

Poor communication between prenatal care providers and the delivery hospital resulted in some increase in direct costs. Excess costs of approximately $159,000 were incurred because tests performed during prenatal care but unavailable to caretakers at the hospital were repeated when the mother was admitted to labor and delivery.

In addition, the cost of HBIG given to infants whose mothers' HBsAg status is not known before 12 hours after birth must be considered. The HBIG costs $16.50 per dose plus cost of administration, estimated at $10.00 per dose. If the data from prenatal testing were utilized, it is estimated that only 450 doses of HBIG would be given each year to infants whose mothers' status is now known at 12 hours after delivery, saving $11,700. Using prenatal laboratory results would reduce total direct cost of the program by about 40%.

CONCLUSIONS

Evaluation of the screening program at LBJ General Hospital has revealed that infants were identified successfully at the time of birth but at greater cost than necessary, and that follow-up has been poor. Note that the carrier rate in this population is no higher than that in the population at large, although indigent populations are generally considered to be at high risk.

The cost-effectiveness of this program is limited in two ways: first, cost is increased by duplication of laboratory testing and by provision of unnecessary HBIG; second, effectiveness of prevention is limited by poor follow-up. Cost of the program might be lowered by improving communication of results from prenatal clinics, so that the costs of repeating the test and of providing unnecessary HBIG could be avoided. Follow-up may be improved by intensive case management, which itself carries associated cost.

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Use of moderate hypothermia during elective craniotomy

Guy L. Clifton, MD
M.L. Christensen

Use of moderate hypothermia as an adjunct to elective craniotomy is described in 21 patients. Systemic hypothermia to 32°C was induced by cooling blankets at a mean cooling rate of 1.6°C/min. Patients were rewarmed at the same rate prior to closure of wounds. There were no hypothermia-related complications and the method increased brain relaxation. The rationale for use of this therapy in elective craniotomy and severe head injury is reviewed.

Dr Clifton, professor and director, Division of Neurosurgery, Department of Surgery, The University of Texas Health Science Center at Houston, 6431 Fannin, Suite 7.148, Houston, TX 77030; Mr Christensen, fourth-year medical student, The University of Texas Health Science Center at Houston. Send reprint requests to Dr Clifton.

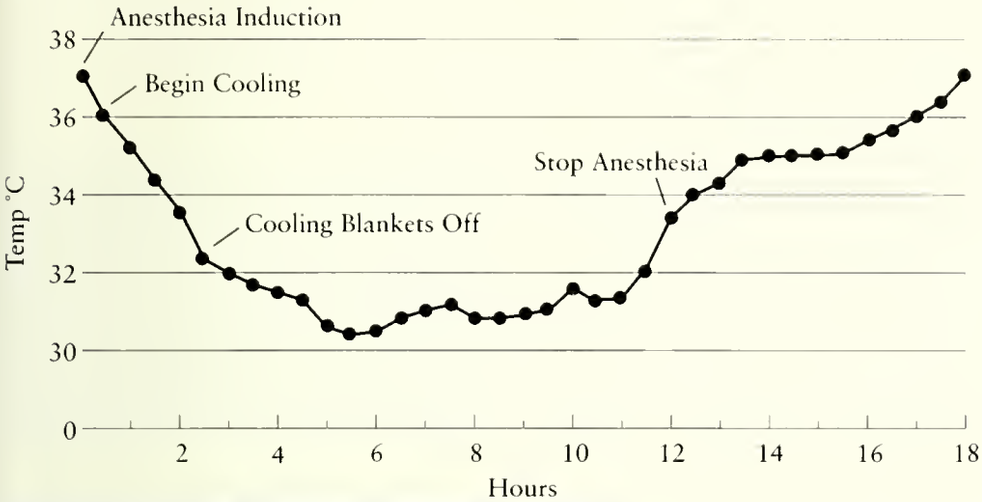
Morbidity from elective craniotomy has been reduced in four ways in neurosurgery. First, the operative microscope, introduced in the 1970s, produced magnification and superior lighting, thereby reducing brain retraction. Second, computerized magnetic resonance imaging has provided specific anatomic detail, allowing a more precise operative approach to tumors and vascular malformations. Third, methods to approach base-of-skull lesions have been developed that substitute retraction of the orbit and zygoma for retraction of the frontal and temporal lobes. A fourth improvement in therapy for aneurysms, tumors, and vascular malformations is development of techniques of endovascular embolization and stereotactic radiosurgery. New techniques of cerebral protection may further reduce morbidity from removal of large tumors and vascular malformations (as well as from traumatic brain injury) by diminishing the secondary responses of the brain to injury.

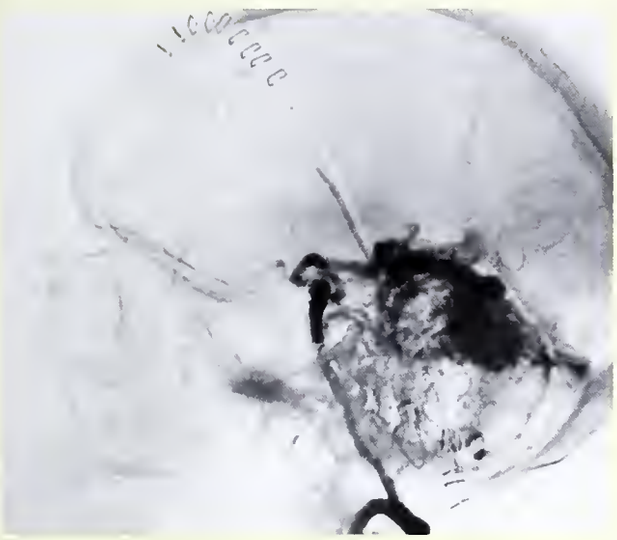
Current clinical techniques of cerebral protection are derived from a new understanding of the brain's response to injury. Standardized rodent models of brain injury have been developed from 10 years of work in our laboratory and other laboratories. (1,2). A damaging biochemical cascade occurs in these models and probably in man, also. This chain of reactions is characterized by excessive release of toxic neurotransmitters, by the resulting abnormal activity of intracellular enzyme systems, and by generation of highly toxic free radicals (3). This cascade can be blocked and the neurologic outcome from experimental brain injury can be improved by experimental pharmaceuticals that selectively inhibit one of these three pathologic processes. Work in our laboratory on brain injury and ischemia and in other laboratories on ischemia has shown that 3° through 4°C of systemic hypothermia, induced either before or after experimental brain injury, is more protective in reducing long-term disability than most pharmaceuticals and potently diminishes the biochemical cascade after injury (4–9). Because of these findings and extensive clinical experience with this modality in the 1960s, we routinely have used surface-induced hypothermia to 32°C in 21 elective craniotomies for large aneurysms, arteriovenous malformations, and tumors to determine safety and to obtain an estimate of efficacy.

METHODS

From January 1990 to July 1991, elective craniotomies for large tumors, large aneurysms, and arteriovenous malformations were performed on 21 patients by one of the authors (GLC). Of the patients undergoing surgery, 3 had arteriovenous malformations, 14 had tumors, 3 had large aneurysms (2 cm or more), and 1 had symptomatic carotid stenosis with contralateral carotid occlusion. Cases likely to require carotid arterial occlusion, those requiring prolonged dissection, those with large tumors with brain compression, and those with large arteriovenous malformations were selected for hypothermia. Hypothermia was not used on routine craniotomies. Patients were anesthetized with fentanyl (or sufentanyl) and forane or isofluorane and paralyzed with vecuronium. After anesthesia induction and positioning, cooling blankets were placed above and below the patient and

Fig 1. Top, Intravascular temperature (measured by Swan-Ganz catheter) of 43-year-old patient who underwent surgery for a cerebellar arteriovenous malformation. Temperature was 36°C after anesthesia was induced and fell to 30° within 3 hours with use of cooling blankets. Patient was maintained at this temperature for 8 hours and then rewarmed during the next 4 hours. Bottom, Preoperative arteriogram shows large arteriovenous malformation fed by the superior cerebellar artery.





turned to 5°C. Temperature was measured by esophageal probe or Swan Ganz catheter; blood pressure, by arterial monitoring. Pulse oximetry was routine. The target esophageal temperature was 32°C; cooling blankets were turned off when the temperature reached 34°C. The patients would continue to cool 2°C after the cooling blankets were turned off. Thirty minutes prior to closing the craniotomy or 1½ hours prior to completion of the procedure, blankets were turned to 37°C. At the conclusion of surgery, paralysis was not reversed and patients left the operating room intubated until core temperature reached 35°C or higher. At this time, muscle relaxants were reversed or discontinued and patients were extubated. Warming units were used in the recovery room to accelerate rewarming. Other postoperative care was as usual. All patients were given phenytoin, 18 mg/kg intravenously during surgery or had therapeutic phenytoin levels preoperatively. Patients with large tumors (14 cases) were give dexamethasone 4 mg every 6 hours. Prophylactic antibiotics were used in all cases. Surgical technique was standardized with use of minimal retraction and the operative microscope in all cases.

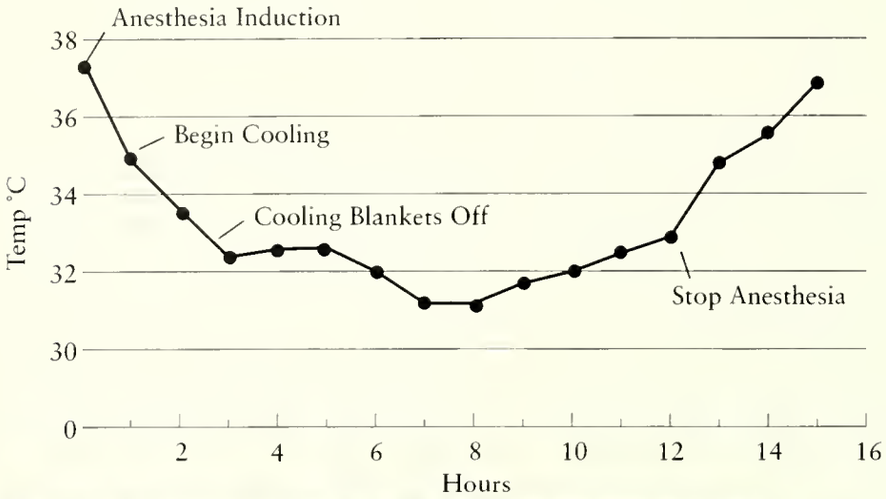
RESULTS

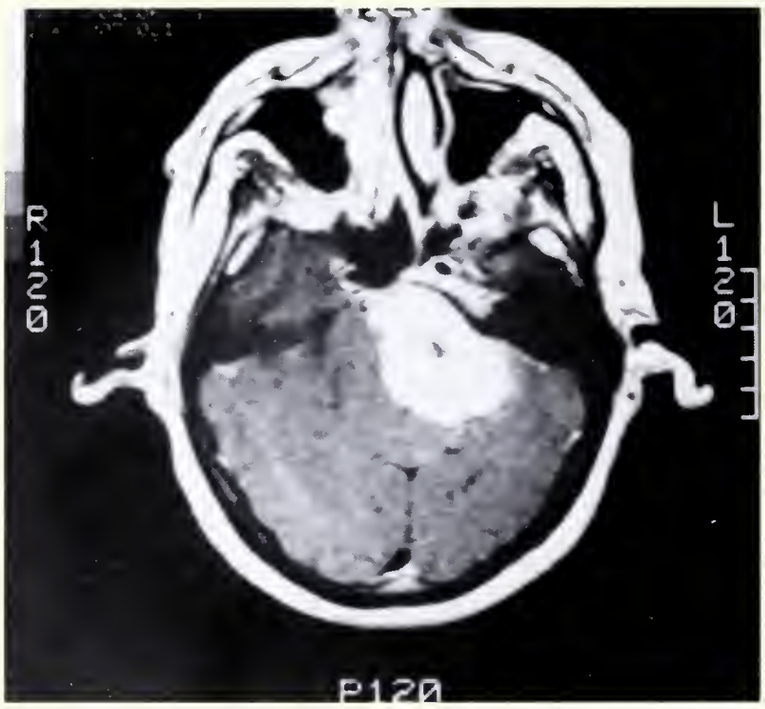
Fig 1, top, illustrates the intraoperative course of a patient with a large cerebellar arteriovenous malformation. The patient's core temperature was monitored with a Swan Ganz catheter. After anesthesia induction, temperature was 36°C. Over the next 3 hours, temperature dropped to 32°C; it remained at 32°C for the next 8 hours. Before the procedure was completed, rewarming was instituted and the patient was extubated at 36°C; Fig 1, bottom, shows this patient's arteriogram. Fig 2, top, shows the intraoperative temperature curve of a 50-year-old patient with a large meningioma of the cerebellopontine angle; Fig 2, bottom, shows his preoperative magnetic resonance imaging scan.

Cooling rates varied from 0.5°C per hour to 2°C per hour with a mean of 1.6°C per hour. Rewarming rates varied from 1°C per hour to 3.5°C per hour with a mean of 1.6°C per hour. The duration of hypothermia (a core temperature no higher than 33°C) varied from 1 to 8 hours (mean 4 hours). Initially, we used 30°C as the target temperature. Midway into the series, we began to use 32°C routinely to reduce the time needed for rewarming and to reduce risk of ventricular arrhythmias.

Complications of surgery occurred in 4 patients. A man with a large craniopharyngioma suffered a delayed epidural hematoma that required evacuation 10 days after surgery. The patient recovered rapidly without new deficits and left the hospital 2 weeks after surgery. One elderly patient with a giant aneurysm of the middle cerebral artery developed an infarction of this artery 3 days after surgery. The patient slowly recovered but with a moderate fixed deficit. A palsy of the seventh cranial nerve occurred in one patient with a 4-cm acoustic neuroma. One patient with an occipital arteriovenous malformation in the calcarine cortex experienced postoperatively an incomplete right homonymous hemianopia, which has persisted. Transient neurologic deficits occurred in 2 patients with large meningiomas but resolved

Fig 2. Top, Intraoperative core temperature of patient with large cerebellopontine angle meningioma. Cooling was initiated after anesthesia induction. Patient's temperature fell from 35°C to 32°C within 2 hours. Hypothermia was maintained for 9 hours prior to rewarming. Muscle relaxants were reversed at 35°C. Bottom, Patient's preoperative magnetic resonance imaging scan. Large meningioma in the cerebellopontine angle was completely removed.





within several weeks of surgery. No other morbidity resulted from surgery and no mortality occurred. Complications attributable to hypothermia, specifically cardiac arrhythmias and intracerebral hemorrhage, did not occur.

Early in this series, one patient developed a metabolic acidosis from shivering in the recovery room and required sedation and muscle relaxants until further rewarming. This patient's muscle relaxants were reversed at 33°C; in all subsequent patients, muscle relaxants were not reversed until core temperature reached at least 35°C. Heart rate fell to a mean of 54 beats per minute during hypothermia (40 through 75 beats per minute) with little change in blood pressure. The 6 patients who were 65 years old or older tolerated hypothermia as well as the younger patients did.

Our impression was that patients recovered more briskly from surgery than is usual, returning to baseline status or better within 24 hours after surgery. A major benefit was hypothermia-induced relaxation of the brain. Only 2 patients required mannitol to be given intraoperatively for additional brain relaxation.

DISCUSSION

Hypothermia has a long clinical history in neurosurgery. Profound hypothermia (8° through 10°C) was first used for cerebral protection in the 1950s, when cardiac arrest was needed for cardiac surgery and extracorporeal circulation was not yet available (10). Ventricular arrhythmias occur at temperatures below 30°C, so the use of profound hypothermia without extracorporeal circulation was short-lived (10). In neurosurgery, the wish for a bloodless operative field led to published reports of more than 100 cases of aneurysms in which surgery was performed under total cardiac arrest with extracorporeal circulation at temperatures of 8° through 10°C (11–14). This technique was abandoned, however, primarily because of a high incidence of postoperative hemorrhage. This method is now used on an occasional basis for aneurysms that are not operable by usual means. Circulatory arrest for neurosurgery will probably be supplanted completely by rapidly developing techniques of endovascular obliteration of aneurysms (15).

The distinction between profound hypothermia with cardiac arrest and moderate hypothermia with intact circulation is important in assessing the clinical potential of this modality. Surface cooling to 30° through 32°C for 2 to 10 days after severe brain injury was reported in more than 120 cases from 1955 through 1974 (16–19). Mortality and morbidity were thought to be reduced by most investigators. Because methods for randomized trials and modern techniques of ventilatory support and airway control were lacking, the use of moderate hypothermia was abandoned, as was the use of profound hypothermia in neurosurgery. The bleeding complications of profound hypothermia (8° through 10°C) were never encoun-

tered with moderate hypothermia (30° through 32°C). Cardiac arrhythmias at temperatures greater than 31°C have been rarely reported. We have found neither of these potential complications to be a problem when temperatures were kept at or above 32°C.

Study of well-characterized animal models has led to a completely new insight in the use of hypothermia in man. Minimal degrees of temperature reduction (3° through 4°C) have been found to have a profoundly protective effect when administered either before or after cerebral ischemia and injury (4–9). Further, this effect is at least as potent as the best experimental pharmaceuticals available (6,7). Data in models of brain injury show that hypothermia blocks the initiating mechanism of the biochemical cascade, excess neurotransmitter release, and also prevents disruption of the blood-brain barrier, which causes edema (5,8,20). It is unlikely, therefore, that moderate hypothermia is simply acting to delay biochemical processes that would occur anyway.

We did not construct the series reported here to prove or disprove the efficacy of moderate hypothermia in cerebral protection. This can be done only by a randomized, prospective study of hypothermia administered within 6 hours of severe brain injury. Such a study is in progress at Hermann Hospital in Houston, Tex, and a multicenter study is being implemented. From the present series, however, we can say that moderate hypothermia (32° through 33°C) in the setting of an operating room is not associated with cardiac or hemorrhagic complications. The brain is relaxed, diminishing the need for diuretics and diminishing retraction. Shivering, which we had presumed could be a problem, did not occur if rewarming was begun prior to closing and completed prior to reversal of muscle relaxants. Cooling and rewarming rates of 1.6°C per hour dictate that the use of hypothermia is practical in cases taking at least 4 hours, but these are also the cases where cerebral protection is useful. The technique worked as well in elderly patients as in the young. Brain relaxation and an impression of more rapid recovery after surgery has led us to use this technique routinely in long cases until such time as randomized trial methodology in severe brain injury produces a definitive answer.

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Medical Networks has excellent career and part-time practice opportunities available for physicians experienced in emergency medicine. In addition to paid $1M/$3M professional liability insurance, our attractive compensation packages range up to $250,000 plus annually. Hourly rate plus incentive packages available.

See our classified ads in this issue for more details, or contact:

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Medical Networks, Inc.
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Houston, Texas 77210-4448

In Houston call: (713) 446-9696
Outside Houston (800) 231-0223

Outstanding Emergency Medicine Opportunities — Sterling Healthcare, Inc., a progressive physician-oriented group committed to the highest standards in emergency medicine, has outstanding opportunities for qualified physicians. Compensation packages include a minimum hourly guarantee plus a percentage of collections, with paid $1M/$3M professional liability insurance included. Physicians also benefit by working in a flexible environment as independent contractors. To obtain more information, contact Sterling Healthcare, Inc., 8700 Crownhill, Suite 600, San Antonio, TX 78209 or call 1-800-999-3728.

San Antonio — The Baptist Memorial Hospital System has opportunities for qualified emergency physicians. This hospital system consists of four level II full-service community hospitals with excellent medical staff, strong administrative support, double and triple coverage, and dictation system. Annual ED volume of 25,000–28,000. Fee-for-service remuneration of $155,000–$205,000 first year. Culturally rich environment, warm climate, and a great place to raise your family. Applicants preferred to be BC/BP in EM or primary care specialty, and have Texas license or applied. Please send CV to Teri Medlar, Emergency Physicians Affiliates, 8700 Crownhill, Suite 600, San Antonio, TX 78209, or call 1-800-999-3728.

Medical Director Opportunity — Emergency Department Medical Director position available in moderate volume Level II facility in the North Dallas area. Qualifications include recent experience in a similar position or board certification in emergency medicine. Compensation based on hourly guarantee plus incentive and monthly stipend. Professional liability insurance is included. Estimated first year: $180,000+. Please forward CV to Sterling Healthcare, Inc, 8700 Crownhill, Suite 600, San Antonio, TX 78209, or call 1-800-999-3728.

Family/General Practice

Austin, Texas — Physician(s) needed for full time, part-time, weekdays, weekends to staff a free standing urgent care center. Remuneration commensurate with experience. Send CV and application to Austin Medicenter, c/o Sheila Twyman, Medical Administrator, 6343 Cameron Rd, Austin, TX 78723 or call 512-467-2052.

FAMILY PRACTICE

Are you ready to enjoy rural life and a two-physician practice? The Atascosa RHI Health Clinic, Inc., a federally funded community health center, located at 310 W. Oaklawn, Pleasanton, Texas, 30 miles south of San Antonio, is the place for you. If interested, please call Jaime Garcia, MD, Medical Director, or Esther Maese, Executive Director, at 512-569-2527.

Family Practice — BE/BC family physician needed to join with 4 other family practitioners in a thriving practice in Beaumont, Texas. Modern, full-service clinic offers a guaranteed salary plus percentage of production and benefits. Send CV to Nancy Bloomfield, 4010 College, Suite 200, Beaumont, TX 77707.

Family Practice Clinic

Enjoy well-established, fast-growing family practice clinic with excellent income potential. State-of-the-art equipment, full lab, x-ray, EKG, therapy plus minor surgery. Louisiana license required. Send CV and application to N.W. Louisiana Medical Clinic, 1850 Martin Luther King Jr. Dr, Shreveport, LA 71107, Attn: Clayton Lane, or call 318-226-1310.

Breckenridge Family Clinic P.A. is looking for a new associate immediately. Terms are negotiable. Prefer board-certified practitioner with dedication to and interest in rural medicine. Contact W.E. Prater, MD, at 817-559-7475 (Grad UTMB '84, John Peter Smith '87) or send CV to 103 S Hartford, Breckenridge, TX 76424.

Scenic Colorado front range community of 30,000, with a strong, growing economic base, needs Family Physicians. Join a group of physicians or establish a solo practice with cross coverage. Full range of family medicine, including OB, available. Hospital offers generous guarantee for the physician wanting to be close to Rocky Mountain recreation as well as metropolitan areas. Call Rita Longino at 1-800-279-5267 or FAX CV to 1-800-467-1246, or send CV to WHS, PO Box 2107, Corrales, NM 87048-2107.

AUSTIN AREA OUT-PATIENT CLINIC

Enjoy a country practice with down-to earth, loyal patients in a practice with strictly controlled hours. Two well-established family practitioners, located 25 minutes from UT, are seeking a third physician for out-patient practice. Full or part-time available, leading to a partnership in two years if desired. Send resume to 209 E Second St, Elgin, TX 78621 or call 512-285-3315, W.T. Biel, MD, or Ken Sherman, MD.

Family Practice — Long established and respected Houston multispecialty group is adding two family practice physicians. Excellent income and generous benefit package with partnership possibilities. Outstanding potential for professional growth. State-of-the-art facility soon to be constructed. For information, call Jerry Nisenson, 713-669-0344, 713-869-3701, or 1-800-944-4047.

Medical Specialist — Rusk State Hospital has opening for a Medical Doctor to provide limited general adult medical services to patients in a state psychiatric hospital. Forty-hour regular duty work week (Monday–Friday; 8 am–5 pm). Rusk is located in the beautiful piney woods of East Texas. Very favorable cost of living, par-

ticularly regarding real estate. Excellent recreational opportunities abound. Requires residency (3 yr) trained BE/BC physician. Must have completed accredited 3-year residency in internal medicine or family medicine. Salary $9,228–$10,935 monthly, DOQ. Contact Rusk State Hospital Human Resources Office, PO Box 318, Rusk, TX 75785. 903-683-3421, ext 3270. EEO/AA Employer.

Family Practice Physician for North Central Texas community. Associate with board-certified physicians — modern clinic building — 70-bed hospital. Salary guarantee — $120,000. Obstetrics not required. Contact: Stan Schuermann, 800-332-8663.

Ambulatory Care — Opportunities available in Alabama, Georgia, Mississippi, Texas, and Florida. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911.

Family Physician — BE/BC family practice physician to join established, growing practice in the beautiful Hill Country. Good benefits, 6-year-old spacious clinic, reasonable call schedule — 53-bed hospital with excellent support staff; OB/ICU privileges available. Mid-Texas Health Care Association, Attn: Yvonne Haug, MD, 1305 N Milam, Fredericksburg, TX 78624; 512-997-7626.

Houston — Hospital-sponsored purchase of retiring physician's practice. Located in suburban west. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911.

Internal Medicine

Fort Worth , Texas
BE/BC Internist -- American Trained -- Stable 10 MD Group -- Adding 7th Internist -- Downtown location – Salary + Bonus + Paid Expenses -- Fee for service practice -- Mail CV: Administrator, The Fort Worth Clinic, 1221 West Lancaster Avenue, Fort Worth, TX 76102

Gold Mine for Internist — Wanted, aggressive and energetic physician, BE/BC to do consultations for a group of family physicians. Must be able to do procedures. Very competitive fee for service income available, including benefits. Salary is based on percentage of collections with a base salary guarantee. Send CV to Nancy Bloomfield, 4010 College St, Suite 200, Beaumont, TX 77707.

Internal Medicine — Over 60 opportunities in Texas. Urban, suburban, and rural locations. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911 or 713-531-0911.

Dallas — BC/BE General Internist to join well-trained, respected internists in group practice at Presbyterian Hospital, a tertiary care teaching hospital. Beautiful new office. Salary and full benefits paid. Send CV to Internal Medicine Healthcare Associates, 8230 Walnut Hill #212, Dallas, TX 75231.

Internal Medicine — Expanding 14-physician internal medicine clinic with 58 years of service in Texas state capital is seeking an internal medicine specialist. We offer a competitive compensation and benefits package, leading to full partnership. Austin offers excellent lifestyle, major university, scenic hill country, lakes, and abundant recreational opportunities. Please submit curriculum vitae to John Guzzino, Administrator, 601 Medical Park Tower, Austin, TX 78705.

Dallas, Texas — Join established, respected practice — North Dallas. 4-way call. $100,000 first year/generous benefits. New clinic with x-ray and lab, adjacent hospital. Family community. Kristin Aldrich, 10983 Granada, Overland Park, KS 66211; 1-800-533-0525.

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OB/GYN — Long established and respected San Antonio solo OB/GYN physician seeking OB/GYN physician will full partnership. A unique OB/GYN practice opportunity. For information, call Lenna Ramirez, 512-923-1116.

OB/GYN — Long established and respected Houston multispecialty group is adding two OB/GYN physicians. Excellent income and generous benefit package with partnership possibilities. Outstanding potential for professional growth. State-of-the-art facility soon to be constructed. For information, call Jerry Nisenson, 713-669-0344, 713-869-3701, or 1-800-944-4047.

Orthopedics

Houston — Southeast. Exceptional opportunity to take over fully established practice from nationally recognized orthopedic surgeon. Stable, diversified growing referral base. Outstanding income potential. Superior opportunity for physician interested in industrial and sports medicine. Ergonomically functional clerical/clinical office. Beautiful modern decor. Professional management and clerical staff, physical therapy and radiology. State-of-the-art computer system. Proximate to Houston's Astrodome, industrial centers, and nationally recognized school systems. Near seven community hospitals. Easy access to Houston's world-renowned medical center, cultural centers, and Clear Lake's beautiful recreational community. Ms Collier, 713-922-5882.

Otolaryngology

Houston — Established practice for sale. Net collections of $530,000 working 4 half-days per week. Heavy surgical practice with room for expansion. For details, contact Practice Dynamics, 11222 Richmond, Suite 125, Houston, TX 77082; 800-933-0911 or 713-531-0911.

Psychiatry

Austin private psychiatry practice seeks general or child and adolescent psychiatrist for full or part-time position. Contact Barry K. Herman, MD, 512-454-9955.

More Outstanding Opportunities from The TEXAS Specialists...

FAMILY PRACTICE

NORTH CENTRAL TEXAS
Family physicians needed. Practice with established primary care group, or independently with shared call. No OB. Interest in pediatrics a plus. Attractive, well-equipped, 56-bed hospital. Competitive incentive package. Contact: Jim Truitt.

EAST TEXAS
Two board certified, recently trained family physicians are seeking additional family physician for associate practice (or solo sharing call) in small university town within one hour of D/FW Metroplex. No OB. Great life style among sophisticated population without the hassles of, but access to, a large city. Lots of recreational and social amenities. Generous incentive package from community hospital to qualified doctor. Contact: Barry Strittmatter.

FORT WORTH
Largest family practice residency program in the country has expanding faculty needs. Several positions available; excellent income/benefits; limited call. Clinical associate/assistant professorship to UT medical school. Call for more information. Contact: Vicki Truitt.

NORTH CENTRAL TEXAS
Popular location, recreational paradise! Need two more FPs to offer full range of family medicine in town of 21,000; easy access to Dallas/Fort Worth. OB optional. Ultra-modern, 200-bed hospital. Excellent referral base and backup. Generous incentive package. This opportunity has it all! Contact: Vicki Truitt.

EAST TEXAS
A financially sound, 48-bed hospital seeks board certified (or eligible pursuing certification) family physician to establish a solo practice. Call sharing and coverage is available from other family physicians in the community. This beautiful rural community is a recreational mecca; hunting, fishing, water sports, camping, etc. Competitive incentive package to qualified physician. Contact: Barry Strittmatter.

CENTRAL TEXAS
Established group of young FPs and well-equipped, financially sound, JCAHO-accredited hospital seek two BC FPs to accommodate increasing patient volume. Full scope of family medicine. Shared call and competitive incentive package to qualified doctor. Major lake, 18-hole golf course. Contact: Barry Strittmatter.

SOUTH CENTRAL TEXAS
Within one hour of San Antonio - South Central Texas hospital seeks additional BE/BC family practitioner for service area of 20,000. OB is available, but not required. Hunting and fishing (fresh and salt water) and other recreational activities abound. Generous incentive package to qualified candidate.
Contact: Barry Strittmatter.

EL PASO
A highly respected and well-established physician in El Paso (population approximately 500,000), wishes to retire. He and the hospital with whom he is associated seek a board certified (or board eligible pursuing certification) family physician to join him and begin to assume his large practice. Competitive benefit package to qualified candidate. Contact: Barry Strittmatter.

FORT WORTH
Family physician needed to deliver basic primary care in "fast track" unit of busy ER. The regular hours of this position will allow you to enjoy a nice lifestyle in a city with tremendous amenities. Salaried position. Call us for details. Contact: Vicki Truitt

INTERNAL MEDICINE

NORTH CENTRAL TEXAS
Popular location, great lifestyle. Three busy internists seek fourth to join practice. Excellent hospital facilities and equipment. Outstanding referral base and backup. Community of 21,000 with easy access to Dallas/Fort Worth. Recreational opportunities abound - and the coverage will allow you time to enjoy it! Generous incentive package. Contact: Vicki Truitt.

D/FW METROPLEX
BC internist needed to fill the position of Director, Department of Internal Medicine of major teaching hospital. Individual selected must possess strong administrative skills, be an effective communicator, committed to primary care medicine, dedicated to quality medical education and willing to provide some direct patient care. Five day work week, superb income, benefits and UT faculty appointment will be offered to qualified individual. Contact: Jim Truitt.

INFECTIOUS DISEASE

FORT WORTH
ID physician needed to manage infectious disease service of major teaching hospital in D/FW Metroplex (100% ID practice). Service includes 10-bed inpatient infectious disease unit and outpatient infectious disease clinic; modern infusion lab. Intern and resident assigned to service. Great position because of its 40-hour work week and very limited call responsibility; excellent income and benefits. Contact: Jim Truitt.

NEUROSURGERY

NORTH CENTRAL TEXAS
Recently trained neurological surgeon seeks associate for regional neurosurgical group. Well-established and growing practice in attractive north central Texas location. Easily accessible to D/FW Metroplex. Modern hospital facilities. Good income/benefits. Many desirable features. Call for details. Contact: Vicki Truitt.

OBSTETRICS/GYNECOLOGY

NORTHEAST TEXAS
Regional medical center serving 200,000 seeks BE/BC OB/GYN for private practice (to share call with three other OB/GYNs). New Women's Center underway. Progressive, family oriented community with strong, diversified economy; excellent schools. Many social and recreational opportunities. Comprehensive incentive package to qualified physician.
Contact: Vicki Truitt.

NORTH CENTRAL TEXAS
BE/BC OB/GYN needed for associate practice in north central Texas community of approximately 21,000 (serving referral area of 206,000). Regional medical center with ultra-modern OB facilities and equipment. Good neonatal support. Area renown for recreational facilities. Easy access to Dallas/Fort Worth metropolitan area. Contact: Vicki Truitt.

ONCOLOGY

FORT WORTH
Full time medical oncologist needed at teaching hospital in D/FW Metroplex, clinical teaching appointment to UT medical school. Manage oncology division, develop full time oncology teaching service. Utilize modern facilities; infusion lab. Regular hours and limited call. Attractive income and benefits. Contact: Jim Truitt.

OTOLARYNGOLOGY

NORTH CENTRAL TEXAS
Regional medical center in community of approximately 21,000 (serving referral area of 206,000) seeks BC otolaryngologist. Associate or solo practice possibilities. Ultra-modern hospital facilities. Area renown for recreational facilities; easy access to D/FW Metroplex. Competitive incentive package to qualified physician. Contact: Vicki Truitt.

NORTHEAST TEXAS
Regional medical center serving 200,000+ seeks additional otolaryngologist for private practice opportunity. Share call with recently trained BC ENT. Progressive, family oriented community with strong, diversified economy, excellent schools. Many social and recreational opportunities. Competitive incentive package to qualified physician. Contact: Jim Truitt.

PEDIATRICS

SOUTH TEXAS
Pediatric group practice. Three American-trained, board certified pediatricians seek compatible associate to join rapidly growing practice in the Rio Grande Valley. Excellent income potential in an area acclaimed for its great climate and recreational opportunities.
Contact: Barry Strittmatter.

NORTHEAST TEXAS
Dynamic group of American trained, BC pediatricians seek fourth associate for group practice in attractive community of 27,000 (referral area of 200,000). Progressive, family-oriented community with strong, diversified economy; excellent schools. Social and recreational opportunities abound. Modern hospital with Level II nursery and designated pediatric care unit. Shared call; excellent income and benefits; early partnership. Contact: Vicki Truitt.

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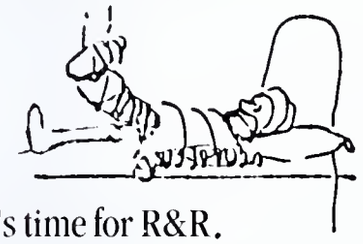

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Expanding 15-Physician multispecialty group has excellent opportunity for a radiologist in friendly West Texas community of 25,000. Adjacent to a 153-bed modern hospital. Excellent guaranteed salary with no first year expenses in addition to benefits. Moving allowance also available. Direct inquiries or send CV to Gail Knous, Malone & Hogan Clinic, 1501 W 11th Place, Big Spring, TX 79720; 915-267-6361.

Diagnostic Radiologist with CT, MR, Interventional, US, Nuclear Medicine skills to join group of seven Board Certified Radiologists. Two hospitals, private offices, service to nearby communities. Centrally located to San Antonio, Austin, Houston, Corpus Christi. Good family environment. Contact James Neumann, MD, Box 3610, Victoria, TX 77903; 512-578-0317.

Other Opportunities

Correctional Healthcare

Full time primary care Physicians & Psychiatrists, statewide adult correctional facility locations, new **salary increases effective 3/1/92/** benefits/Physician student repayment program. Inquiries: TDJC, Box 99, Personnel Annex, Huntsville, TX 77342-0099 or contact Glynda Baker, **(409) 291-4020.**

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FAX 713-784-9260
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FOR SALE OR LEASE

Medical Equipment

For Sale — Complete turnkey office XMA X-ray System, low prior usage, installation and onsite instruction for office staff, includes QX70 processor and accessories. Contact 817-759-4298.

Office Space

For rent or lease in Amarillo, Tx. Medical office 2000+ square feet. Six exam rooms, lots of storage, and telephone system. Next to established pharmacy — very reasonable. Contact Phil Durham or Ray Doherty at 806-383-3377.

For Sale — Medical science center office at 711 West 38th, Austin, Texas. Approximately 1,170 square feet. $129,900. Contact Clarke Witt, MD, at 817-481-0012.

Practices

Selling Your Practice? We offer practice evaluations & brokerage, physician recruiting, and partnership buy-in services. We can help you make the right decisions. For a free brochure, call or write: PRACTICE DYNAMICS, Dept T, 11222 Richmond, Ste 125, Houston, TX 77082; 713-531-0911.

Family practice in community near Houston. Enjoy small town atmosphere near city amenities. Well-established with offices adjacent to hospital. Transition available. For information package, contact Business & Professional Associates at 713-782-8888. TMH-1422.

SE Houston — Psychiatric practice with hospital component. Offices near hospital. Excellent for addition/expansion of your practice. Substantial opportunity for growth. Lowered competition. For information package, contact Business & Professional Associates at 713-782-8888. TMH-1438.

Family Practice — Partnership practice for sale in suburban area. Tired of single or rural practice. Good opportunity. Please contact AD Box 805, 401 W 15th St, Austin, TX 78701.

Radiology office practice with contemporary 1-story building, including 2 R & F rooms, 1 clinical room. Well-located in stable neighborhood near clinics and modern acute-care hospital. Historic city, coastal bend area of Texas. Older records microfilmed. Immediate partnership leading to practice purchase, or direct outright sale. Full resume with first inquiry to TMA, AD Box 406, 401 W 15th St, Austin, TX 78701.

Vacation Homes

Cayman Islands — Private — One-bedroom condo, oceanfront, 7-mile beach, fully equipped, walking distance to restaurants, shopping, etc. Low: $1,000; High: $1,250 US per week/2 persons. 416-737-7667.

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CME / Continuing Education Directory

Courses

JANUARY

Cardiology

Jan 11–15, 1993
Cardiology Conference at Snowmass. Snowmass, Colo. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Jan 21–22, 1993
Introduction to Mitral Valve Repair. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Jan 24–26, 1993
Congenital Heart Disease in the Adult. San Diego. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Jan 29–31, 1993
New Diagnostic & Therapeutic Techniques in Clinical Cardiology. Lake Buena Vista, Fla. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Gynecologic Surgery

Jan 16, 1993
Flexible Office Hysteroscopy. Dallas. Contact Presbyterian Healthcare System, Office of CME, 8160 Walnut Hill Ln, Dallas, TX 75231 (214) 891-2323

Orthopedic Surgery

Jan 15–17, 1993
Southwestern Orthopaedic Recertification. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Psychiatry

Jan 16, 1993
Biological Basis of Mechanics Underlying Bipolar Disorder. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Infectious Diseases

Jan 14–17, 1993
Infectious Diseases Update for the Primary Care Physician. Lake Tahoe, Nev. Contact Office of CME, The University of Texas Medical Branch, Rte J-34, Shearn Moody Plaza, Galveston, TX 77550 (409) 772-7834

Obstetrics and Gynecology

Jan 21–23, 1993
Diseases of the Vulva and Vagina. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Jan 22–23, 1993
Breast Disease 1993. Houston. Contact The University of Texas Medical School at Houston, Office of CME, 1100 Holcombe Blvd, HMB 15.1509, Houston, TX 77030 (713) 792-5346

Oncology

Jan 30, 1993
Cancer Update on Melanoma/Sarcoma. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

FEBRUARY

Anesthesiology

Feb 26–28, 1993
Anesthesia Conference of Obstetrics. Houston. Contact The University of Texas Medical School at Houston, Office of CME, 1100 Holcombe Blvd, HMB 15.1509, Houston, TX 77030 (713) 792-5346

Cardiology

Feb 1–5, 1993
Echo Hawaii. Maui, Hawaii. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Feb 1–3, 1993
Cardiovascular Conference at Snowshoe. Snowshoe, WVa. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Feb 10–13, 1993
Cardiovascular Conference at Snowbird. Snowbird, Utah. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Feb 15–19, 1993
Cardiovascular Conference at Hawaii. Mauna Lani, Hawaii. Contact American College of Cardiology, Extramural Programs, PO Box 79231, Baltimore, MD 21279-0231 (800) 257-4739

Gastroenterology

Feb 19–20, 1993
Advances in Gastroenterology. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-6020

Neurology

Feb 11–13, 1993
Recent Advances in Neurology. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

Oncology

Feb 6, 1993
Basal and Squamous Cell Head & Neck Cancer. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Feb 12–13, 1993
Clinical Implications of Prostate Cancer Biology. Houston. Contact The University of Texas M.D. Anderson Cancer Center, Conference Services, Box 131, 1515 Holcombe Blvd, Houston, TX 77030 (713) 792-2222

Pathology

Feb 11–14, 1993
Cytopathology Review Course. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Plastic Surgery

Feb 26–27, 1993
Mayo Clinic Plastic Surgery Symposium. Phoenix. Contact Mayo Clinic at Scottsdale, 13400 E Shea Blvd, Scottsdale, AZ 85259 (602) 391-7447

Psychiatry

Feb 27, 1993
Geriatric Psychiatry Review. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

MARCH

Audiology

Mar 12, 1993
Audiology Conference. College Station. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Critical Care

Mar 6–11, 1993
Critical Care Medicine Course. Oklahoma City. Contact Oklahoma University Health Science Center, Dept of Medicine, Rm 3SP 400, PO Box 26901, Oklahoma City, OK 73190 (405) 271-5904

Emergency Medicine

Mar 12–13, 1993
Annual Emergency Medicine Review. Austin. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Endocrinology

Mar 27, 1993
Clinical Endocrinology Symposium. Houston. Contact The University of Texas Medical School at Houston, Office of CME, 1100 Holcombe Blvd, HMB 15.1509, Houston, TX 77030 (713) 792-5346

Obstetrics and Gynecology

Mar 17–20, 1993
Controversies in Female Issues & Endocrinology. Puerto Vallarta, Mexico. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Orthopedic Surgery

Mar 10–14, 1993
Texas Orthopaedic Surgery Workshop. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Otorhinolaryngology

Mar 20–21, 1993
Endoscopic Sinus Surgery. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Physical Medicine & Rehabilitation

Mar 15–25, 1993
Comprehensive Review Course in Physical Medicine and Rehab. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Plastic Surgery

Mar 6–9, 1993
Dallas Rhinoplasty Symposium. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Psychiatry

Mar 13, 1993
Diagnosis & Management of Obsessive Compulsive Disorder. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

APRIL

Family Practice

Apr 21–25, 1993
Family Medicine Review. Austin. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Oncology

Apr 21–24, 1993
Minorities, the Medically Underserved & Cancer. Houston. Contact Baylor College of Medicine, Office of CME, One Baylor Plaza, Houston, TX 77030 (713) 798-4941

Apr 22–24, 1993
Controversies of Bone Marrow Transplantation. San Antonio. Contact Methodist Hospital, 7700 Floyd Curl Dr, San Antonio, TX 78229 (512) 692-4884

Orthopedic Surgery

Apr 2–4, 1993
Southwestern Orthopaedic Surgery. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Pediatrics

Apr 15–17, 1993
National Pediatric Diseases Seminar. New Orleans. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

MAY

AIDS

May 3–7, 1993
HIV/AIDS Conference. New Orleans. Contact Delta Region AIDS Education and Training Center, 1542 Tulane Ave, New Orleans, LA 70112 (504) 568-3855

Pathology

May 13–15, 1993
Current Issues in Surgical Pathology. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

Surgery, General

May 3–5, 1993
Current Topics in General Surgery. Dallas. Contact The University of Texas Southwestern Medical Center, Office of CME, 5323 Harry Hines Blvd, Dallas, TX 75235 (214) 688-2166

JUNE

Obstetrics and Gynecology

June 9–13, 1993
The Female Patient. S Padre Island. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Oncology

June 4–5, 1993
Cancer in Men. Austin. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Otolaryngology

June 23–25, 1993
International Conference on Cochlear Implants. San Francisco. Contact University of California at San Francisco, Extended Programs in Medical Education, Rm LS-105, San Francisco, CA 94143-0742 (415) 476-4251

JULY

Obstetrics and Gynecology

July 1–5, 1993
Highlights in Women's Health Care. Santa Fe, NM. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

AUGUST

Internal Medicine

Aug 2–7, 1993
Internal Medicine Review. S Padre Island. Contact Scott & White Memorial Hosp, Office of CME, 2401 S 31st St, Temple, TX 76508 (817) 774-4083

Calendar of Meetings

• Denotes Texas meeting

February

Feb 26–28, 1993, Austin
• TMA Winter Leadership Conference
Contact Jon Hornaday (conference program) or Dale Willimack (facilities/arrangements), Texas Medical Association, 401 W 15th St, Austin, TX 78701 (800) 880-1300

April

Apr 2–4, 1993, Scottsdale, Ariz
American Society of Cytology Meeting
Contact Yener S. Erozan, MD, 1015 Chestnut St, Ste 1518, Philadelphia, PA 19107 (215) 922-3880

May

May 13–16, 1993, Houston
• TMA Annual Session
Contact Dale Willimack, TMA Department of Annual Session and Meeting Management, 401 W 15th St, Austin, TX 78701 (800) 880-1300

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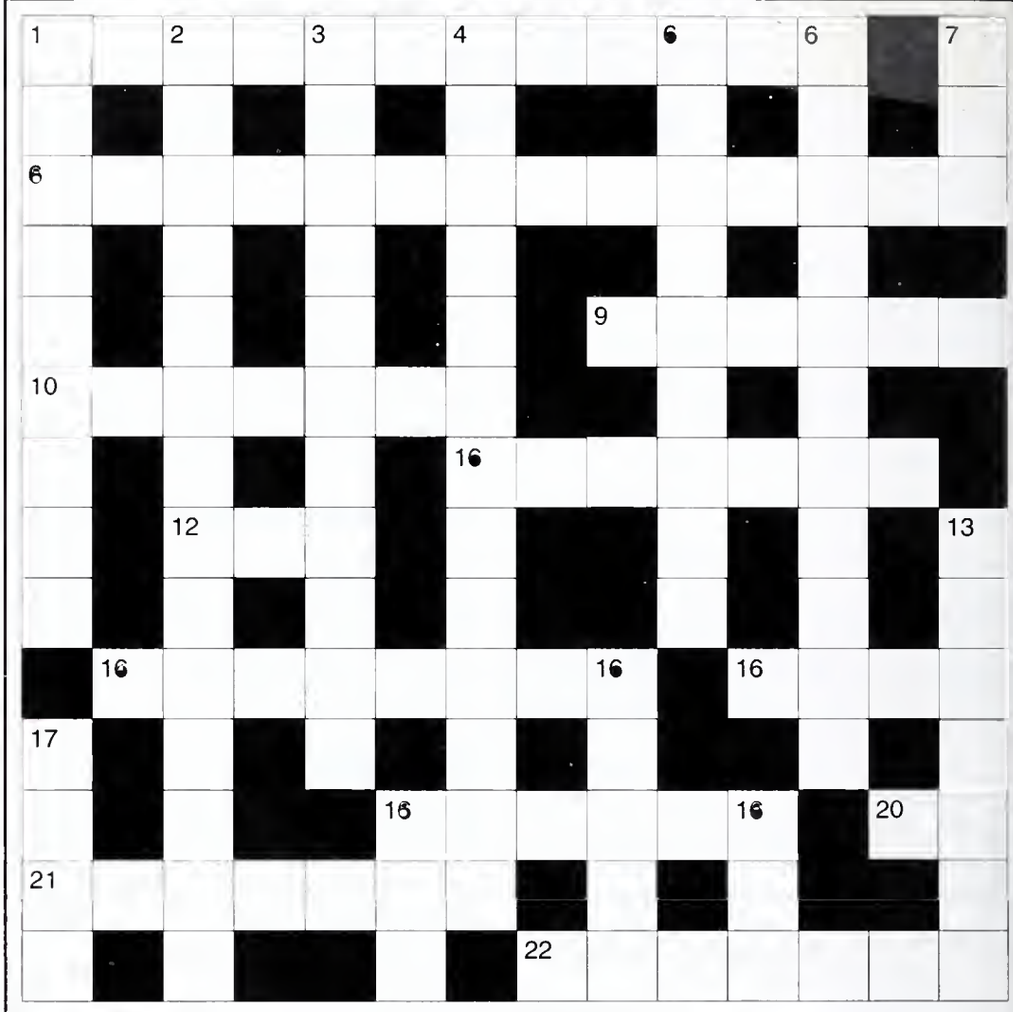

ACROSS

1. A steroid that is formed during the metabolism of progesterone, found in the urine during pregnancy (12)
8. The result of a noninvasive procedure using ultrasound useful in the diagnosis and differentiation of heart murmurs (14)
9. A sleeplike state in which reaction to the environment is diminished although awareness is not impaired (6)
10. Prefix denoting the brain (7)
11. A complex nitrogen-containing ring structure and parent compound of the porphyrins (7)
12. New or newly formed (3)
14. The tendon of the gastrocnemius and soleus muscles (8)
16. Tissue damage caused by such agents as heat, chemicals, electricity, sunlight or nuclear radiation (4)
18. An involuntary violent reflex expulsion of air through the nose and mouth (6)
20. Prescription abbrev, on retiring (2)
21. Numerous narrow, transverse infoldings of the inner membrane of a mitochondrion, plural (7)
22. Absence of the lens of the eye (7)

DOWN

1. Unusually early development of mental or physical traits (9)
2. A powerful diuretic administered orally or parenterally effective in promoting sodium and chloride excretion (10,4)
3. ——— lipoidica, patchy degeneration of the skin causing areas of white scarring and thinning (11)
4. A tricyclic antidepressant used to relieve all types of depression (13)
5. Affecting the contraction of heart muscle (9)
6. Spasm of the larynx (11)
7. Brachium (3)
13. Inability to recognize the import of sensory impressions; the varieties are distinguished as auditory, gustatory, olfactory, tactile and visual (7)
15. A state of natural unconsciousness, during which the brain's activity is not apparent but can be detected by means of an electroencephalogram (5)
17. A tubelike structure or channel, especially one for carrying glandular secretions (4)
18. Salt (3)
19. Diagnostic inspection aided by anesthesia, abbrev (3)

Solution on p 30.

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